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ABSTRACT

By working together, pooling resources and energy, both health centers and schools can do more to help children to be ready to learn and to reach their full potential as citizens. This book focuses on establishing links between schools serving low-income children and community or migrant health centers. The book is organized into three chapters corresponding to critical steps in the development of a school-linked program and contains advice, recommendations for further reading, and checklists. The first chapter guides readers from initial consideration of a school-linked program through the organization of a planning group. This chapter provides an overview of issues that sites should anticipate in the process of program design and implementation. The second chapter explores key issues to consider during the actual design and implementation of the program. This chapter is organized by key topics, including gathering data, organizing support, deciding which services to provide and where, determining a staff configuration, establishing a structure, financing the project, addressing confidentiality and consent issues, cultivating community involvement, and building in plans for self-assessment and evaluation. The third chapter examines issues that develop during ongoing operation and expansion of school-linked health initiatives and key issues which affect program stability and sustainability, especially long-term financial concerns. Four appendices contain a glossary of health and education terms, reference charts and sample forms used by an existing site, contact information, and profiles of the nine sites studied. (SD)

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LINKING COMMUNITY HEALTH CENTERS WITH SCHOOLS SERVING LOW-INCOME CHILDREN

PS 025308

Bureau of Primary Health Care

THE PEOPLE WE SERVE... THE PEOPLE WE ARE

U.S. Department of Health and Human Services
Public Health Service
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The HRSA BPHC would like to thank Leila Fiester and Carolyn Marzke for their authorship of this publication. HRSA BPHC would also like to thank and acknowledge the U.S. Department of Education for their advice and assistance.

HRSA BPHC Project Officer: Laura Visser

AN

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DEPARTMENT OF HEALTH & HUMAN SERVICES
BUREAU OF PRIMARY HEALTH CARE

Public Health Service

Health Resources and
Services Administration
Bethesda MD 20814

June 1, 1996

Dear Colleague:

We are proud to present you with this publication entitled Linking Community Health Centers with Schools Serving Low Income Children: An Idea Book. The goal of the Idea Book is to promote linkages between schools and community and migrant health centers (C/MHCs).

The Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC) continually seeks to identify and support successful models of health care delivery that increase access to comprehensive primary and preventive care and improve the health status of underserved and vulnerable populations. The models of school health services represented here provide you with examples of linkages that have worked despite obstacles.

In June 1995, HRSA/BPHC and the Department of Education shared with you a letter which provided some initial ideas and rationale for linkages between C/MHCs and schools. Every day there are more and more challenges to face in the form of increased need and shrinking resources to provide health care to children and adolescents. By working together, pooling resources and energy, both health centers and schools can do more to help children to be ready to learn and to reach their full potential as citizens.

With this book, we seek to provide you with practical advice and tips from the field from school health and education professionals who have collaborated and who know what works. We hope it will inspire you to begin your own school health linkage.

Sincerely yours,

Marilyn B. Gaston, M.D.
Assistant Surgeon General
Director

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In addition, several expert advisers—principals, teachers, school nurses and school nurse coordinators, school-based or school-linked health clinic staff, and other health or education practitioners—offered advice or reviewed drafts of the book. Their comments were invaluable in making the book user-friendly and useful to an array of readers. Advisers included David Benson, Sandy Boyd, Michael Currie, Edward Hinman, Darhyl Jasper, Addie Johnson, Barry Lackman, Tony McCray, Pat Papa, Gaynelle Pearson, Joseph Powlis, Cordelia Rabb, and John Santelli. Christel Brellochs generously agreed to the inclusion of her chart of essential and optional services for school-based health centers in the appendix of reference materials.

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Introduction

For many communities that are grappling with shrinking resources and burgeoning social needs, programs linking education, health, and social services aren't just expedient—they're beneficial and necessary. In hopes of addressing health needs that impede children's learning, many communities are developing comprehensive service initiatives in neighborhoods that have limited or no health services for low-income students and their families. Many of these initiatives include school-health linkages designed to improve students' readiness to learn as well as their health status, school attendance, and school performance, and to reduce school dropout and teen pregnancy rates.

School-health linkages today can draw on two decades of experience in designing, planning, implementing, and funding successful programs. Researchers estimate that approximately 500 programs provide school-based or school-linked health services in 38 states.[1] Several states have launched initiatives addressing statewide school-linked services, and anecdotal evidence shows that children at these sites miss less school and gain much-needed access to health and human services.

Establishing and maintaining strong links between schools and health providers isn't always easy. Program leaders frequently struggle with community concerns, logistical problems, reimbursement obstacles, institutional turf battles, and confidentiality and consent requirements. But these obstacles *can* be overcome. This Idea Book explores these issues; offers strategies for planning, designing, implementing, modifying, and expanding school-health programs based on the experiences of nine diverse sites across the country; and guides the reader to useful resources.

Purpose and Overview of the Idea Book

This Idea Book was written for practitioners and policy makers who recognize the importance of interactions between education and health efforts and want to create links between schools and community health-care providers. Several excellent guides have been written on how to establish school-linked or school-based health programs, and this book is intended not to duplicate them but to augment them with lessons learned from case studies. This book focuses specifically on establishing links between schools serving low-income children and community or migrant health centers—just one of many types of possible linkages in the broader field of comprehensive services. Community or migrant health centers (C/MHCs) are health care organizations with a mandate to serve residents in underserved communities.

Although this book explores programs involving schools that serve low-income students, the lessons learned are relevant to all schools and all students. Many of the issues and strategies that affect these programs are common to a variety of links between schools and service providers. Our premise is that practitioners who want to establish these linkages will benefit most from detailed examples and advice from fellow practitioners, given in their own words—and that the in-depth look at issues provided by these case studies will complement the more general overviews and the how-to guides available elsewhere.

[1] Brellochs, C., and Fothergill, K. (1995) Ingredients for success: Comprehensive school-based health centers. Special report on the 1993 National Work Group Meetings. Bronx, NY: The School Health Policy Initiative. To order, contact the Initiative at Montefiore Medical Center, Albert Einstein College of Medicine, (718) 515-5601.

Definition of Terms

C/MHCs are funded by the Bureau of Primary Health Care (BPHC), located within the U.S. Department of Health and Human Services' Health Resources and Services Administration.

Community health centers provide comprehensive primary and preventive health care to medically underserved, vulnerable populations. **Primary health care** services include preventive health services such as health screenings and immunizations; treatment of minor injuries, health conditions, and illnesses; and management of chronic diseases. Health centers are located in communities where there are financial, geographic, or cultural barriers to primary health care for a substantial portion of the population.

Migrant health centers provide comprehensive primary and preventive health care to migrant and seasonal farm workers and their families. Clinicians in these health centers are often bilingual, provide culturally competent services, and are familiar with the complex health problems faced by farm workers and other vulnerable populations.

Health Care for the Homeless programs improve access to primary health care and substance abuse treatment for homeless people and people at risk of homelessness. Of the more than 700 organizations receiving federal funding through the C/MHCs or BPHC's Health Care for the Homeless grant program, approximately 250 provide school health services.

School-linked health services, defined in greater detail in Chapter 2, are medical, psychosocial, and dental services provided through special arrangements between schools and other agencies but not necessarily located at the school. **School-based health services**, also defined in more detail later, refers to services delivered on school grounds. In both cases, the services may be available full- or part-time.

For additional definitions, please see the glossary of health and education terms in Appendix A.

This book examines a range of programs that reflect a continuum of services, from basic to comprehensive health programs. The continuum of human services offered through comprehensive initiatives can and does extend beyond the scope of sites selected for this book, so planners of new linkages should consider using the guidance offered here to link their programs with additional community resources.

The Idea Book is organized into three chapters corresponding to critical steps in the development of a school-linked or school-based program. This format allows a range of readers—parents, principals, teachers, school nurses, district administrators, and many others—to find the information most relevant to their needs and experiences as they evolve over time.

The first chapter guides readers from initial thinking about a school-linked program through the organization of a planning group. It provides information and advice on critical first steps and an overview of issues that sites should anticipate as they move into the more detailed process of program design and implementation.

The second chapter explores key issues to consider during the actual design and implementation of the program. We combine the discussion of these two steps into one chapter because many implementation issues that sites described could—and perhaps *should*—have been addressed during planning; sources often said that if they had anticipated certain issues, they would have done things differently. This chapter is organized by key topics: gathering data and organizing support, deciding which services to provide and where, determining a staff configuration, establishing an organizational and management structure, financing the project, addressing confidentiality and consent issues, establishing referral systems, cultivating community involvement, and building in plans for self-assessment and evaluation. Most barriers that sites encounter fall into these categories, and our sources used a variety of strategies to address them.

A third chapter examines issues that develop during ongoing operation and expansion of school-linked and school-based health initiatives. Because few of the sites had progressed beyond initial implementation and early operation, the discussion is based on the experience of a few sites as well as information from the more general school-based/school-linked health literature. This chapter also considers key issues that affect program stability and sustainability. A central question for school-linked and school-based programs is how to build long-term support and funding so that services will be available after initial seed funds are exhausted. This may not become a critical matter until several years after the initial planning effort, but the elements required for stable operations and sustainable funding should be incorporated from the very beginning of the planning process. A growing number of school-health programs are confronting barriers to long-term sustainability as they near the end of demonstration grant periods and must fight for dollars in an era of diminishing resources. Many have adjusted their approach in response to this reality.

In addition, each chapter of the Idea Book contains "tips from the field"—advice and suggestions from the sites interviewed—and recommendations for further reading. In particular, we refer to documents produced by school-linked programs and other experts in the field with direct experience in planning, designing, implementing, and operating programs. Each chapter concludes with a checklist that is intended to help new planners begin identifying and addressing their own needs, issues, and solutions.

Appendix A contains a glossary of health and education terms. Appendix B contains a reference chart in addition to sample forms used by

a site profiled for this book. Appendix C contains contact information for further assistance. Full profiles of the nine sites studied for this book are contained in Appendix D: Profiles of Selected Sites.

Natural Links Between Local Health Centers and Schools That Serve Low-Income Students

Community and migrant health centers, usually located in areas with high numbers of at-risk students and few health or social service resources, make natural partners for schools that serve low-income children because both work to provide services to children in need. As one teacher explained,

> *A lot of our kids are here without shots, without the appropriate care that they need, because [their parents] can't reach the services—they don't have transportation or the motivation of getting up and going across town. Whereas at the school, teachers can make sure the kids get the services.*

Although they operate in different institutional environments and provide different professional services, the efforts of high-poverty schools and C/MHCs are mutually reinforcing. Many C/MHCs describe their interest in schools in these terms: If health care providers can't get kids to the health centers (a common problem in low-income communities), then bring the health centers to the kids. By collaborating to bring services to a shared target group, C/MHCs and high-poverty schools can help one another improve health and educational outcomes for children in their communities.

Links between high-poverty schools and C/MHCs also support the broader goals of education and health care reforms that emphasize school readiness and access to health care. Educators and school or school district administrators interviewed for this book identified connections between health linkages and:

- The National Education Goals, especially the goals of readiness to learn, school completion, and safe and drug-free schools
- School-level reforms in which teachers are developing curricula with real-world contexts and applied living skills; in these cases, school-health linkages teach students to integrate their learning with their actions
- Goals of raising educational standards for all children, because healthy students are better able to learn
- Education improvement for homeless children and youth, because health services attract these students to the school where they can then receive an education

In addition, school-health programs seek to increase children's ability to focus on learning in the classroom and decrease the problems and behaviors that lead to absenteeism, suspension, and expulsion or dropping out. Teachers find that students who are not distracted by unmet health needs are more motivated and attentive in class, and that students who can receive health services through a school-linked or school-based program usually spend more time in school. School-health programs are especially important as more students with serious health conditions—such as cancer, kidney disease, quadriplegia, cerebral palsy, hemophilia, or organ transplants—have begun to attend regular schools and need assistance with complicated medication schedules and other health-related issues. School principals frequently told us that their schools' links with health services allowed them to continue teaching students who otherwise would have missed school because of poor health.

Although all students benefit from health services, these programs are especially useful for reaching special-education students, who tend to need health care more often, and high-risk children, who often form close bonds with the health professionals who provide much-needed services. In some cases, school-based or school-linked programs prevent health problems from occurring simply because health services become available where before there were none.

School-health partnerships extend beyond mere co-location of medical services in schools to collaborative efforts to create healthy environments for children. In many school-health programs, medical staff help teachers develop curricula, clinic staff teach regularly in classrooms, and school and medical staff serve actively on each other's planning and oversight committees.

Background on Case-Study Sites

We selected nine sites for this study in consultation with the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services, and with the U.S. Department of Education. Our criteria included high involvement of low-income students and variety in client demographics, urbanicity, program design and services provided, geographic location, funding sources, duration of program, and number of schools or students served. Although this was not a scientific sample, these sites were selected to cover a range of needs, issues, and strategies that are typical of many other sites.

Our sample included five urban and four rural sites, and represented a mixture of populations including African American, Hispanic, Native American, migrant, and homeless students and communities. Although six sites had school-based programs, and one had a mixed school-based and school-linked design, several of the school-based sites began with simple linkages. Some sites offered comprehensive health services and links with other human services, while others provided very basic health care. The sites included newly implemented programs that faced planning dilemmas as well as mature programs in their second decade of operation that had adapted goals and services to meet changing community needs. Some served only a few students a week, while others served thousands a year. Although many of the programs implemented their current designs in the late 1980s or early 1990s, they often were built on longstanding informal relationships between schools and health centers or on previous, less-comprehensive linkages. The sample included:

- **Cherry Street Health Services and Henry Paideia Academy, Grand Rapids, Michigan**. Rotating medical and dental teams visit this urban school and six others for two- to three-month periods. The linkage provides access to medical and dental care for 2,187 students in kindergarten through sixth grade. Ninety-seven percent of the students are African American. Ninety percent are eligible for public assistance. The major funding source is a local hospital.

- **Clinica Adelante and the Queen Creek School District, Queen Creek, Arizona**. This school-linked program offers health services to students and families—many of whom are migrants—in a small, rural community, through a satellite C/MHC. Students range from pre-kindergarten through high school. Sixty percent of the students are Anglo and 35 percent are Latino. Thirty-four percent live in poverty. Major funding comes from the U.S. Public Health Service, third-party patient revenue, and fees.

- **Fort Pierce Family Service Center and Fort Pierce Elementary School, Ft. Pierce, Florida**. This comprehensive family service center, located on school grounds, targets the medical needs of children and youth from birth through age 18 as well as the multiple social needs of families. Fifty-one percent of the students are Anglo, 38 percent are African American, and 11 percent are Hispanic or Haitian. Seventy-seven percent are eligible for free or reduced-price lunch. Major sources of funding are federal Public Education Capital Outlay funds, a state Full Service Schools grant, and a special taxing district for children' services that awards grants to two of the agencies co-located at the family center.

- **HealthNet, Inc. and School 50, Indianapolis, Indiana**. This school has one of three school linkages operated by the health organization. The program, which is part of a broader integrated services initiative called Bridges to Success, provides basic health care at a clinic based in an elementary school. Half of the students are African American and half are Anglo. Seventy-five percent are eligible for public assistance, and 80 percent receive free or reduced-price lunch. Major sources of funding are the Robert Wood Johnson Foundation, the United Way, and local foundations.

- **Konawa Community Health Center and Pleasant Grove School, Konawa, Oklahoma**. This school is one of several in eight rural communities where children and youth receive health education, screenings, basic services, and medical referrals from a mobile van. Ninety percent of the students are Anglo; the rest are Native American or African American. Eighty-five percent receive free or reduced-price lunch. Major funding sources are federal grants, Medicaid/Medicare reimbursement, patient fees, local foundations, and some state funds.

- **Logan Heights Family Health Center and The Place, San Diego, California**. Students at this alternative school for homeless youth receive basic health services, health education, and medical referrals from clinic staff who visit the school one day a week. Sixty-seven percent of the students are Hispanic, 19 percent are Anglo, and 13 percent are African American. Approximately 60 percent are eligible for public assistance, although far fewer receive it. Funding comes from federal grants (Healthy Tomorrows, Health Care for the Homeless, and Healthy Schools/Healthy Communities).

- **Multnomah County Health Department and Jefferson High School, Portland, Oregon**. This program is one of seven comprehensive, school-based health clinics in Portland-area high schools. The clinics serve more than 4,400 students in grades nine through twelve; Jefferson's clinic serves about 650 students a year. Forty-eight percent of the students are African American, 31 percent are Anglo, 7 percent are Asian American, 8 percent are Hispanic, and 1 percent are Native American. Thirty three percent are eligible for free or reduced-price lunch. Funding comes from the county's general fund and third party reimbursement.

- **Southeast Lancaster Health Services and King Elementary School, Lancaster, Pennsylvania**. Between 400 and 600 students a year receive basic health services at this school-based program, one of six state pilots and one

of two school linkages administered by the community health center. Sixty-six percent of the students are Hispanic, 28 percent are African American, and the rest are Anglo or Asian American. Ninety percent are eligible for free or reduced-price lunch. Major funding sources are state and federal block grants and Medicaid reimbursement.

- **Valley Wide Health Services and Sierra Grande School, Blanca, Colorado**. This school-based clinic emphasizes health education, pregnancy prevention, and case management for students in a very large, rural area with few alternative sources of health care. Other schools in the area obtain school-linked services from the same community health center. More than 300 students receive services at Sierra Grande; 82 percent are Hispanic, 5 percent are Asian American, and 13 percent are Anglo. Eighty percent are eligible for free or reduced-price lunch. Major sources of funding are federal grants and a state block grant for child health.

After conducting telephone interviews with sources at these sites and creating profiles of their experiences (focusing on a specific school, where appropriate), we chose five programs to visit. We selected sites that could illustrate typical challenges, useful strategies, or innovative solutions, and strove to maintain the same balance among criteria used during the initial selection process.

Conclusions

One of the remarkable aspects of school-linked and school-based approaches to improving the health status of schoolchildren is the diversity of strategies that schools and community or migrant health centers use to address the challenges they face. Each community has different needs, interests, and priorities; each operates within its own set of constraints. There is no ideal service design, approach, organizational structure, or staffing configuration for school-linked or school-based health services. Each component must respond to local needs, preferences, and political context. At the same time, certain common experiences in designing, implementing, and sustaining programs offer guidance for future school-health linkages.

Program Design Strategies

Most programs, even those that planners consider school-linked, have some school-based components in order to deliver services as close to students as possible. Sometimes this means operating across the street rather than on school grounds, and sometimes it means delivering only part-time, temporary, or noncontroversial services—or services that do not demand much space—on school grounds and providing the rest through referrals.

In addition, although many programs begin as efforts to address specific health needs, preventive health care is a crucial component of school-linked and school-based health services and one that health professionals feel should be included whenever possible. Mental health services also are in high demand among school-linked and school-based programs and tend to be added to the design over time as students learn to trust providers and make their mental health needs known.

Finally, schools and health centers don't wait until they have designed a perfect linkage before starting implementation. Because so many factors are involved in establishing a linkage—and because the services are so desperately needed—planners lay the groundwork for a program and then help it evolve, rather than waiting for an ideal arrangement or set of circumstances

that may never occur. School-linked and school-based health programs may offer a limited set of initial services for a variety of reasons, but these programs still add to the long-term capacity of communities to meet the needs of children in a significant way. The goals and opportunities of school-linked and school-based health programs change over time, as staff become more familiar with students' needs and the community begins to rely on and trust the program. Many collaborators view school-linked programs as a beginning rather than a complete solution.

Strategies Supporting Program Implementation and Operation

School-health linkages rely on both formal and informal means of planning and managing their efforts. While some formal arrangements may be necessary to establish clear lines of authority, informal communication and participation by school and health staff, parents, and community members—on a continual basis and from the very earliest planning stages—are essential to a program's successful implementation and operation. In particular, communication with and involvement of a broad base of parents and community leaders helps school-linked and school-based health programs anticipate and resolve potential controversy around services. However, planners must balance their desire to reach program goals with decisions to avoid controversy—especially when the program is designed to address sensitive health issues.

Issues and Strategies for Monitoring and Sustaining Programs

Program planners and operators are still struggling to find solutions to many of the issues involved in evaluating and funding school-health initiatives over the long term. School-linked and school-based health programs frequently rely on single-source funding for start-up costs, for example, but find it difficult to maintain stable funding after the first few years of operation. Medicaid and other reimbursements are harder to obtain than many planners anticipate—because of managed care requirements and other barriers—and are not sufficient to sustain a program without additional funding.

Federal or private funding is essential to getting many school-linked and school-based programs off the ground. When asked to evaluate the governmental role in supporting school-linked health services, most sources called for increased funding and fewer restrictions on how programs may allocate grant money. State or local policies or funding—often linked to mandates for AIDS education, concern about high teen pregnancy rates, or broader maternal and child health initiatives—provide the impetus for some school-health linkages in addition to giving planners early legitimacy and community support. Planners may shy away from some state funds, however, because of restrictions on services that may contradict some programs' goals.

Program evaluation is the last piece of the puzzle to fall into place for most school-health initiatives. Most sites recognize that evaluation should be built into a program from the beginning, and are dissatisfied with their limited capabilities for evaluation, but lack the time, funding, infrastructure, or expertise to improve data collection and analysis.

First Thoughts and First Steps

Before the actual creation of a school-health linkage—the detailed planning, design, and implementation stages—can begin, someone must first recognize and communicate the need for such a linkage and explore the feasibility and options available for developing one. During this somewhat invisible phase, which may involve only a few people, planners ask the most basic questions: *Why should we establish a school-health linkage? What are the potential benefits? Who else is likely to be supportive? To resist the idea? Who should be involved in a planning process?* The answers help determine the program's basic components and form the information base that supports design and implementation.

Drawn from the experiences of the sample sites, this section summarizes catalysts and initial goals for school-linked and school-based initiatives as well as steps for building interest in and a base of support for such a project. It also introduces key issues that should be considered immediately—even though they play out later in the planning and implementation process—because they guide the selection of participants for planning.

The Catalyst for School-Health Linkages

The motivation for developing a school-health linkage usually comes from (1) a recognition by educators, parents, and/or community members that unmet health needs interfere with students' education, and/or (2) a recognition by health center staff or administrators that many potential clients who lack access to health care could be reached through the school system. Educators, health professionals, and communities see school-health linkages as a way to address these concerns. The impetus can begin on the front lines of service delivery or at almost any administrative level.

The Impetus for a School-Health Linkage Can Come From Many Sources

The impetus for the Fort Pierce (Florida) Family Service Center, which places nurse practitioners in schools, came from the school district's director of student services, who used data on high poverty levels, poor access to health care, limited public transportation, and high levels of health and education risk among children to gain community support for a school-health linkage. Together, the director of student services and various community groups convinced school staff and administrators to pursue the idea, and planners turned to the community health center for support. The health center—which had adequate staff but lacked space—saw the connection with schools as a way to gain both space and a link with the community. A formal agreement between the health center and the school board gave the school system responsibility for providing the site, facility, and equipment and the health center responsibility for staff, funding, and oversight of operations. The health center's medical director, the district's director of school services, the school site principals, and the site coordinator jointly developed the family center program.

Valley Wide Health Services in Alamosa, Colorado, became involved in school-based clinics when teachers at a high school where many of the junior girls were pregnant came to the health center for guidance. A physician and the director of Valley Wide approached the school superintendent (who was also the school's principal) and offered to provide health services at the school, including reproductive counseling. This service slowly grew into a school-linked health program that also provides screenings, primary care, and mental health referrals.

At Clinica Adelante in Arizona, health center leaders decided after six years of operating a mobile health van that they could provide more systematic services through full-time satellite clinics. At the same time, the school district realized that the schools' toughest problem wasn't the quality of teaching—it was the social, economic, and personal problems that interfered with students' learning. The school system developed a comprehensive education plan that integrated the community's resources to support the education of all students—and the linkage with the health center fit into these efforts.

Teachers, school nurses, or principals may advocate establishing a school-health program to help students who are unable to concentrate in class because of health problems. "If a student has a healthy mind, he's more ready to absorb learning," said a lead teacher in an urban elementary school. "Children that are receiving health services are not as sluggish, they're more motivated, they're more alert. If you get them at the beginning, alert and motivated, you can do a little more with them."

Many educators also initiate health links in an attempt to reduce student absences. Explained one teacher:

> *We get notes [saying], "Johnny didn't come to school yesterday because he had to go to the clinic." Or parents will bring Johnny in to school and then take him out again at 9:00 because he has to go to the clinic. Then he misses school for the rest of the day. With a clinic in the school, the children would not have to leave the school grounds; the appointments could be centered around the child's time. If the child is in the middle of reading, the appointment could be set during a resource period. Everything would work around the child, not the child working around the agency.*

School nurses may seek school-health linkages because of their experiences on the front lines of school health. As growing numbers of students with special health needs enter mainstream schools, school nurses may initiate links with health programs in order to increase the level of support available to students. A school nurse coordinator in a metropolitan area, for example, where in 1994 nurses reported 84 major health conditions among public school students, views school-health linkages as an important way to help seriously ill students attend school as much as possible. To serve these students, school health staff must spend more time in contact with parents and the student's primary and specialty physicians, make sure that the school has the equipment and medication to administer treatment in school, obtain documentation to ensure that the school is allowed to treat the student, and provide infrastructure (e.g., longer testing times, larger bathroom stalls, large-print books, wheelchair ramps) to make sure the student has proper access to classrooms and learning opportunities. Health clinic staff can help school nurses meet these needs. Similarly, for the growing numbers of students on mood-altering medications for conditions such as depression, Attention Deficit Disorder, or manic depression, school-based or school-linked health staff can administer daily doses and interact with the child's other physicians to help them determine when to adjust dosages.

State or local policies or the availability of new funding may also provide the impetus for school-health linkages:

- In Lancaster, Pennsylvania, the catalyst for a school-based linkage was a state initiative through the department of maternal and child health that funded six pilot programs. Health center staff say that the state grant gave planners early legitimacy and community support for the effort.

- The teen pregnancy program that formed the basis of a school-linked mobile health unit in rural Konawa, Oklahoma, was part of a state-wide response to the fact that the state had one of the highest teen pregnancy rates in the country. When state law mandated AIDS education, the clinic expanded its health and sex education activities.

- In Portland, Oregon, planning for the first school-based clinic was instigated by the director of the county health department, who had received information from a foundation that provided grants for such projects.

The nature of the impetus for a school-health linkage affects the way in which collaborators—and, later, community members—view and plan the program. Linkages that begin as part of a larger reform effort instead of as an isolated program, for example, may find it easier to garner early support and reduce community concerns. Clinica Adelante's school-linked program in Queen Creek, Arizona, falls into this category: The clinic had hoped to design a school-based health program but community concerns about a direct health role for schools made this impossible. But after the school district invited the community health center to open a clinic in a strip mall across from the school, where a family center designed by the school system was already located, the process of designing and establishing the new linkage proceeded quickly.

The motivation for developing a school-health linkage also influences the program's initial goals, which in turn affect the later stages of planning, design, and implementation. The most common goals are (1) to increase access to health care for students, and sometimes their families; (2) to address students' health needs so they do not miss or drop out of school; and (3) to improve education by reducing health barriers to learning. Linkages that are based on the goal of treating a specific problem, such as teen pregnancy, tend to provide specific—but possibly limited—services, while the more general goal of improving all students' access to health care may require a broader, more comprehensive approach. Programs motivated by a desire to improve general health often take a more preventive approach than those designed to solve a particular health problem or to identify medical needs. For example, the first goal cited above—increasing access to health care—usually translates into efforts to provide basic health screenings, the second goal—providing health services to keep students in school—often leads to family planning and pregnancy services, and the third goal—improving students' health to reduce learning barriers—often leads to programs that deliver acute care and coordination with social services.

Who Are Your Natural Supporters? Identifying Early Planning Partners

Although strong partners emerge most visibly during the actual planning of a school-health linkage as key players are drawn into a growing circle of supporters, every program begins with a small number of early supporters who share an idea or conviction. If you are the initial planner, the challenge is to find your first partner. The experiences of the sample sites show that this search can lead almost anywhere—there is no simple prescription for finding partners—but often begins with personal connections with colleagues in related organizations.

This first group of planners may be small, but it should be as diverse as possible. Natural supporters include the strong and vocal parents, teachers, school nurses, and principals who can be found in every community, health center staff, and other medical practitioners. Other partners include parent organizations; school district and health center administrators; and representatives of state or county departments of education, health, and welfare.

Less obvious but important supporters include local clergy, leaders within the community's ethnic or racial communities, social activists, and volunteers who share a passion for solving the problems of disadvantaged populations. At one site, for example, a linkage began when a van driver, hired by a community clinic to transport homeless youth to the health center, met the charismatic head teacher of an alternative school while making his rounds; the van driver introduced the clinic's medical director to the teacher and together they began designing a school-based clinic.

Based on our sites' experiences, initial partners should have (1) the ability to attract support or interest to the linkage, either through a network of personal connections or because of professional status (e.g., a top school or health administrator); and (2) enough commitment, initiative, time, and energy to get the project off the ground. Sources at successful school-health linkages suggest focusing efforts first on a small group of key people interested in promoting the concept of the linkage before expanding to include a wider but less easily coordinated group of collaborators. This allows collaborators to move quickly and in concert to build a solid base of support that will attract potential supporters. In Portland, for example, the initial planners—health department staff, local politicians, and a social activist—gained financial backing from county legislators for the concept of the linkage before sitting down to plan specifics with the school superintendent, principals, and school staff.

Starting with support from the top—in Portland's case, the county commissioners and the superintendent of schools—helps planners move quickly to flesh out their goals. "Start with something simple—one or two pages of bullet explanations" of needs, issues, and proposed services, advised one key planner. "People at the top don't have time for more than that." In Portland, once the top administrators were on board, the key planners set out to find partners with very specific qualities. They asked for principals who could respond to community concerns, were willing to collaborate with health professionals, and headed schools that needed health services. The initial planning group also asked the superintendent to identify an administrative link above the principal level (e.g., an assistant superintendent) as a liaison.

The strategy of asking only for cooperation and school space for a clinic was successful in attracting early partners because it didn't require their financial commitment, but as Portland discovered it can backfire in the long run because it sets a precedent of placing the financial burden primarily on one stakeholder. When this program first began, planners were willing to accept any available space. During implementation, daily use of the facility made it clear that space and quality issues needed to be addressed—but the school felt it had given the initiative all that the health department had asked for. Planners have had to address this issue repeatedly as the program expands.

Using Existing Data to Communicate the Need for a School-Health Linkage

School-based and school-linked health programs must meet student and community needs in order to generate support. Preliminary discussion of school-linked services often is motivated by the experience or observations of an individual or group of providers—but existing school and health data will likely point to other issues that might be addressed through school-linked services, and can broaden initial perceptions of the problem. Gathering existing evidence and communicating to others the case for school-linked health services is an important step in thinking about a program.

Formal needs assessment that gathers new information and supplements existing data is a useful tool during planning; we discuss it later in this book. However, informal compilation of readily available information helps guide the earliest efforts to increase awareness and build support and participation.[2] Planners suggest collecting data that tend to be easily available from local health departments or school districts, including:

[2]In fact, planners should not attempt a large-scale community needs assessment too early in the process, before all the key paly ers are on board. Collaborators want to be part of the information-gathering process because the findins can drive so much of the program that emerges.

- School dropout and absence rates
- The number of students who are uninsured, lack access to health care, or are eligible for Medicaid
- The rates of chronic health conditions such as asthma or allergies among the target population
- Hospitalization rates among the target population
- Local teenage pregnancy, birth, abortion, and sexually transmitted disease (STD) rates
- Suicide rates, frequency of mental health crises for the target population, and availability of mental health services
- Tobacco, alcohol, and drug use among the target population
- Existing community resources—What health services does the target population now have? How are these resources used? What are their advantages and drawbacks?
- Immunization rates upon student entry into school

Planners also suggest assessing the community's general views on schools, health services, and health education: Who will be most likely to support and help develop the program? Who might have concerns about the program? The answers to these initial questions will make it easier to form a productive planning group and to anticipate issues to address during program design.

A Checklist for Initial Thinking About a School-Health Program

What are the needs in your community that would be best served by a school-linked or school-based health program?

- [] high poverty, lack of access to health care
- [] high rates of health conditions that interfere with schooling (e.g., allergies, asthma, skin conditions, tuberculosis, diabetes, seizures, cancer, kidney impairment, depression, anorexia, hemophilia, cystic fibrosis, cardiac disability, severe headaches, juvenile arthritis)
- [] high rates of teen pregnancy
- [] high suicide rates among school-age children and youth
- [] frequent mental health crises among school-age children and youth
- [] tobacco, alcohol, and drug use among children and youth
- [] high school absence and dropout rates
- [] high numbers of uninsured students and students without access to health care
- [] high numbers of children born into poverty, with addictions, or below normal birth weight
- [] high numbers of homeless, neglected, or abandoned children and youth

Where can you find convincing documentation of these needs?

- [] local health department
- [] school district central office
- [] state departments of child and maternal health, child welfare
- [] state school nurse association
- [] National Association of School Nurses[3]
- [] health care providers (e.g., local hospital or community health center)
- [] existing state or local coalitions of education, health, or social service professionals
- [] previous surveys by unbiased community organizations

What are the likely benefits of building a school-health linkage in your community?

- [] direct, accessible services
- [] free or low-cost services or sliding-scale fees
- [] increased knowledge about health risks among high-risk populations
- [] reduced disease rates
- [] reduced teen pregnancy rates
- [] improved school attendance, performance, and completion
- [] opportunity to teach self-care skills in an age-appropriate sequence
- [] healthier children and parents over the long term, through health education

What are the likely obstacles to a school-health linkage in your community?

- [] lack of facilities
- [] lack of funding
- [] difficulty in obtaining staff
- [] lack of support from key stakeholders
- [] community controversy

Who is most likely to support your school-health program, and what strategy will you use to engage this support? (List specific people and organizations in your community.)

Supporter	Strategy
Teachers	_____
	_____
	_____
Principals	_____
	_____
	_____
School nurses	_____
	_____
	_____

[3] Located in Scarborough, Maine. Call (207) 883-2117 for more information.

School or health administrators

Medical practitioners and providers

State or county health and education representatives

Clergy, religious groups

Parents, parent groups

Leaders of local ethnic/racial communities

Students

Civic activists

Volunteers

Other

Who is most likely to have concerns about a school-health program, and how will you address their concerns?

Also consider:

- [] Conservative political or religious groups
- [] Medical practitioners, providers, or professional organizations who may feel threatened

List the individuals and groups in your community who should be involved in the early planning process, and consider how each stakeholder can best contribute to the group effort. Try to choose a broad but small first set of collaborators to increase its effectiveness.

Collaborator	**Contribution**

For more information (additional references on pp. 73-74):

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Nuts and Bolts of Program Design and Implementation

When the general case for school-linked services has been outlined, a set of core supporters organized, and community support assessed, it's time to move on to detailed design and implementation. This process often begins with expanding the planning group to include all key players identified during the initial design process and conducting a more detailed and broad-based community assessment to inform specific decisions about the target group, program location, and mix of services. Other key topics include community relations; parent involvement; staffing configurations, roles, and issues; establishment of an organizational and management structure; funding and reimbursement; coordination of referrals to and from the program; consideration of confidentiality issues; resolution of parental consent needs and concerns; and development of procedures for continuous self-assessment and evaluation.

Establishing a Core Planning Group

Every plan for a school-health linkage needs a core planning group to carry the project from concept to reality—people who can help assess needs, gather information about other linkage models, gauge public support for the linkage, help assure funding, and develop consensus on goals and services. In urban areas, which tend to have many large factions and special-interest groups, the key players are likely to include members of every stakeholding group. In rural communities, a small group of parents and other leaders typically takes responsibility for new initiatives—and, as one planner notes, "unless you get those people on board, you may as well pack up your suitcase and go home."

Typical key planners include school principals, teachers, parents, special-education professionals, health professionals, health center administrators, and community activists. The most productive core planning groups tend to include upper-level decision makers, frontline practitioners, and consumers, so that all perspectives are represented. Having a diverse planning group usually increases the community's investment in the program's success. In Indiana, for example, in addition to the planners who initiated the integrated services project that includes the school-health linkage (the superintendent of schools and the president of the local United Way), key partners included a coalition of community leaders interested in education, a county health and hospital corporation, a city network for employment and training, local community centers, and the Chamber of Commerce. A core planning group dedicated 10 percent of its time to developing the initiative; participants held a planning retreat and met regularly to identify implementation steps, review needs assessments, and plan linkages with schools.

Key players often play different roles in the planning group based on their areas of expertise. At one site in the sample, an activist who was lobbying the state legislature for programs serving pregnant or parenting teens became involved in the county health department's efforts to establish school-based clinics. The activist and health department staff built support for the concept of school clinics among the county commissioners, one of whom was a former state legislator who then helped build support at the state level. The commissioners quickly approved a proposal for a school-based clinic. Backed by the county commission's promise of funding, health department staff suggested to the superintendent of schools that the clinics could improve adolescent access to health care and address the county's high teen pregnancy rate. The superintendent supported

the idea and appointed a liaison to the health department. At each step of the support-building and planning process, new players with unique perspectives and skills joined the core group.

Whatever the composition of the core planning group, sources at all sites warned that a communication gap tends to separate educators and health care professionals and that it can stand in the way of program planning. "At times, we almost needed a translator," said a planner at one urban site; on several occasions, planners would walk away from a meeting thinking that everyone understood what had been discussed, only to discover later that members had different interpretations based on misunderstood concepts, vocabulary, and expectations.

These differences are often very fundamental. For example, for a health center a "client" is the child seeking services, while schools may also define clients as the child's family, the school's neighborhood, and the local government. "Comprehensive health services" is a term used by health professionals to describe a particular health care package; school staff may define "comprehensive services" as a broad range of services that include but go beyond health care. "Confidentiality" also has different meanings for school and health professionals, who operate under different institutional protocols. The solution: Always try to explain and discuss issues in the simplest terms possible, and devote some planning time to defining terms.

When stakeholders are not aware of or involved in planning school-health linkages, programs usually spend more time cultivating community or school support during implementation, and in some cases the actual program design is affected. In Fort Pierce, Florida, for example, the family service center's planning committee included medical representatives but not the practitioners who would actually work in the clinic, who had not yet been hired. In one mix-up, planners overlooked the clinic's need for hot water but medical staff disagreed—and this feature had to be added after construction ended. Some examining rooms also had to be redesigned to accommodate services that frontline staff found necessary.

On the other hand, planners of a linkage at one rural site in the sample attributed much of their success to the fact that they did *not* have multiple committees and advisory panels involved in their effort and did not solicit community consensus before proceeding. Working with prominent farmers, a local grocer, and some teachers, planners identified the problem (teen pregnancy) and offered a solution (school-linked health education). The informal planning process kept planners from getting bogged down in procedure and protocol and did not give any resistance the time or forum to develop into a major conflict. "In a community that is largely Roman Catholic and Hispanic you have to wonder how they might feel about giving students birth control information," recalls the former superintendent of schools at that site. "We wondered if it would backfire on us. But there was no backlash whatsoever."

In rural areas, where a few people often share the decisionmaking roles, the involvement of a few key community leaders in planning may be just as important as including a range of participants. Valley Wide Health Services attributes its school clinic's initial success to the fact that the health center's physician was a well respected member of the community, so people trusted his opinions and did not challenge him. The health center also was well established in the community, which gave the planners legitimacy. Planners also attribute their success to the closeness of the community, a large but sparsely populated area where residents know or know of each other and where most of the local leaders have spent their entire lives.

Parent Involvement

Parents of elementary-school students are frequently active in school issues; parents of middle- and high-school students often are concerned about their children's access to reproductive services. In both cases, parents have an interest in the way that a school-health linkage may change their lives.

Parent involvement in planning and designing school-health linkages, especially from an early stage, gives school health programs valuable perspectives, broader investment in program success, and an opportunity to address any concerns parents might have about services before they become full-blown issues or compromise patient confidentiality. Parent involvement in school health programs also can improve family awareness of health needs and services, make it easier to collect information needed for financial reimbursement, or fulfill a legal need for consent for services.

School-linked or school-based health services can help parents as well as students by providing easily accessible opportunities for health education. As one elementary school teacher explained:

> *We get a lot of young parents who don't really know the importance of health care. If [services] are housed here, the health agency can work more with parents. It's easier for parents to stop in to find out what it is their child needs. When [health or parenting] workshops are provided at the school, parents seem to come out more.*

Sources at all sample sites recognized the importance of parent involvement in their linkages and said students would benefit if health services also reached their families. But few sites had broad or extensive involvement of many parents during the early stages of the linkage (beyond responding to community needs assessment surveys or attending town meetings) and sites that were not designed as family-oriented service centers often had trouble getting parents and families involved—either because the health program lacks the resources to meet their needs, parents' work schedules prevent them from participating, or neighborhood crime makes it unsafe to visit the school during non-work hours.

In retrospect, many sources said they could or should have involved more parents, early and continuously, in program planning and design. Sites that did not cultivate parent involvement had to rely on outreach efforts after the program began or make extra efforts to respond to individual parent concerns each time they arose. Typically, clinic staff made a point of accepting parents' phone calls immediately, taking time to explain the clinic's goals and practices, initiating contact with parents more frequently—in person or by telephone—and inviting the parent to attend appointments with his or her child. At several sites, health staff built support by inviting parents to tour the clinic; when they visited, staff reassured parents that the clinics would encourage students to discuss health issues with their parents and would not perform abortions—a common misperception about health clinics that serve adolescents. One clinic also placed an outreach worker on staff to make home visits.

These efforts improved parents' understanding of the clinics—but early involvement in establishing the program would have given parents a more central role to play. "You have to [build support among] the majority of the parents," said a planner of Multnomah County's school-based clinics. "You really have to listen behind the din...because there is no way you can avoid this kind of controversy."

Additional Tips from the Field

- Involve a broad sample of community members in planning in order to build ownership, smooth out relationships, and share resources. Suggested participants include members of neighborhood or ministerial organizations, merchants, and representatives of public youth agencies operating in the community.

- Whenever possible, seek the involvement of supportive parents and parent organizations from an early stage of planning.

- Include special-education and mental-health professionals in planning to ensure that the program considers a range of needs and services.

- Allow the planning group adequate time to find a facility, address legal and policy issues, research other programs, and obtain funding. "In my naivete, I said we'd be in [the school] in a month," recalled one key planner. "Actually, it took 14 months."

Community Needs Assessment as a Process and Product of Planning

Most school-linked initiatives emerge as a response to the experiences of people directly involved with children in schools, health clinics, and neighborhood programs. Every day, community members, teachers, principals, physicians, and nurses see the needs of children and work to address them. A community needs assessment builds on this experience to document the nature and extent of the problem, to identify available resources for addressing it, and to establish a baseline against which to measure progress. A community needs assessment is important not only for the information it produces, but also as a process for building support for and participation in the design of a solution. Needs assessment at the school level is also a required step for some private, state, and federal grants. Finally, the process of gathering the data needed for needs assessment lays the groundwork for later program evaluation—an aspect that early planners often overlook although it is crucial to longterm funding and self-assessment.

The needs assessment process may be a formal undertaking, involving significant research and data analysis, interviews, and focus groups with community members. It may also be a more informal effort to assemble evidence and talk with key individuals in the community. In either case, the important thing is to talk with parents, community members, students, and health and education professionals. By the

end of a community needs assessment, planners should have a good feel for (1) the physical and mental health, education, and social needs of students; (2) the major concerns and priorities among stakeholders, (3) major issues and potential conflicts to anticipate, and (4) available resources, including potential funding sources and sources of in-kind support.

One-third of the sites in the sample reported that needs assessments conducted during the early stages of planning helped keep their programs on track and demonstrated the level of community support the program had established as it moved toward implementation. For example, the advisory committee for the community center in Alamosa, Colorado, conducted a community assessment that found parents extremely supportive of counseling or educational services involving nutrition, eating disorders, sex education, and self-esteem; encouraged by this finding, the health center's director of adolescent health made a formal presentation to the school board, which approved a school-linked clinic. Similarly, in Multnomah County planners conducted community assessments that measured income levels, pregnancy and school dropout rates, and availability of medical services to identify the school with the greatest needs; the planning group targeted this site to host the county's first school-based clinic. Supported by this assessment data, the school district liaison met with the principal, vice principals, and health department staff to discuss the clinic; the principal was at first reluctant but was convinced by the data that he should support the project.

How do you conduct a good needs assessment for planning purposes? First, talk with staff in each school that will be affected to ensure that the program will coordinate effectively with education programs, identify potential barriers, and gauge the political climate. Next, talk to students who will be affected about their health concerns and needs—either through a survey or in personal interviews. An 11-page student survey conducted by the Multnomah County Health Department, for example, elicited information on how students obtain health care, how they use school clinic services, student health risk factors, school and student safety, and emotional and mental health issues. (See Appendix B for excerpts.) Other useful strategies include conducting focus groups with parents and other community members and conducting public opinion polls.

A Community Needs Assessment Can Lay the Groundwork for a Comprehensive Educational Plan that Includes School-Linked Health Services

A community needs assessment conducted by the school district in Queen Creek, Arizona inspired community leaders to develop an education plan that included links with a community/migrant health center. The needs assessment revealed that more than 60 percent of the students were economically disadvantaged and that many were at risk of dropping out of school. Students "may be hungry, or beat up, or anxious, or pregnant, or suffering from some terrible combination of fears and psychic injuries....And students in trouble cause trouble," the assessment team found:

> The toughest problem in education is not the quality of teaching. It is the social, economic, and personal problems of the students...problems that prevent students from learning...and problems that the schools and teachers cannot help. If we could solve the human problems, the teachers could solve the learning problems.

The plan Queen Creek developed to address these problems included the school-linked health program, vocational education programs, counseling, and other services—"a unique system in which the needs of the at-risk student are addressed in a holistic manner."

Conducting Focus Groups with Parents and Community Members

Focus groups and town meetings with community members or parents can provide valuable feedback and support. In Indianapolis, for example, members of Bridges to Success (BTS)[4]

[4]The umbrella reform effort that encompasses the school-based clinic program profiled for this book.

interviewed parents and community leaders—especially clergy and business people—to identify the issues that affected student achievement. BTS also conducted focus groups, telephone interviews, and surveys of area residents to identify health care issues and asked teachers, students, and health care providers to identify student needs. Responses showed that students often came to school with malnutrition, head lice, fevers, and other illnesses that interfered with education. Planners used this information to design the program and to build community support for a school-health program.

Public Opinion Polling

Public opinion polls are a particularly effective means of assessing community needs, especially in politically conservative communities, because they provide hard data that can be used to support the need for school-health linkages. "Polling is the most convincing thing you can do to convince school districts to support [a linkage]," said the former director of public affairs for the Multnomah County Health Department. Polls can show the depth of public support for school health programs and can underscore the need for school-health linkages by revealing the lack of access to services or the health problems that affect education. Polls also can indicate the most effective way to market services, where to focus public education efforts and which issues to concentrate on, and which strategies are most effective. Collaborators in Portland conducted three public opinion polls over a six-year period—first, to establish the level of support for the concept of school-based health clinics, then to measure support for a clinic to be located at a particular high school, and finally to gauge support for plans to make birth control available at the clinics and to elicit opinions on other health issues. Findings from each poll influenced plans for program location, policies, and funding.

Polls need not be hard to conduct—in fact, making the policy decision to take a poll may be the most difficult part of the process. Sample questions, adapted from Portland's poll, might be:

> **Do you think it is a good idea or not a good idea to have student health clinics in** [name of city] **public high** [elementary, middle] **schools? Do you think it is a good idea or not a good idea to have student health clinics provide services including routine physical exams, wellness exams**, [list any other services]?

Experienced planners also offer the following tips:

- Work with a professional pollster from your community who is not affiliated with a single political group or has links with many, so your results will have credibility
- Have the school or school district, health center, and pollster decide together what to measure and how to design the poll
- Have the results reported back to you in a public setting so there is no question about credibility

After polls, focus groups, and other assessments are completed, planning partners need to consider and incorporate the community's view of the appropriate role of schools in health programs in order to minimize resistance to the linkage. This can have a profound effect on program design. Clinica Adelante, for example, addressed community concerns by making the health services school-linked rather than school-based, maintaining a low profile, creating separate institutional roles for the school and clinic, and providing services that met specific needs identified by the community.

Community Relations: Turning Doubters into Supporters

School-health linkages frequently generate controversy. Some communities resist any role for schools in providing health care; others are

Additional Tips from the Field

- Establish connections with other youth-involved agencies, such as county and state commissions on children and families, or coalitions of many youth and family agencies. These groups often conduct community assessments and you may be able to collaborate with them. Your involvement will also help you build a network of supporters and will give you credibility in the community as someone who is well-intentioned—and not just pushing his or her own agenda.

- Use a community assessment to identify key issues that could be addressed by a school health center: youth violence, gangs, high tuberculosis or pregnancy rates, lack of access to medical care, student absenteeism, child abuse, drug abuse. Circulate your findings among the decision makers in the community to draw attention to the problems and to show your school health program as part of the solution.

concerned about specific components, particularly birth control. Opposition can seriously hinder or even derail a school-health program and undermine the linkage's goal of unifying community efforts to better serve children and families, so program planners should make an extra effort to include the community and address any concerns directly.

Unfortunately, most program planners focus on goals and services and consider public relations only as an afterthought, at best. Planners in Portland, for example, say they ignored community relations until they were almost ready to open their first school-based health clinic—and then faced picket lines and acrimonious public forums. At this site, which had support from county commissioners and the school board, the principal met with parents to address their concerns about services, and clinic staff invited parents to tour the clinic. The uproar subsided but planners learned a crucial lesson: Community outreach must be an integral part of all stages of planning, should predate the opening of a school-health program, and should include efforts to build a solid base of community support as well as proactive media strategies that help explain the program to community members.

Build a Solid Base of Community Support

Before announcing any activities, planners should approach key elected officials and religious leaders who are likely to support the program to describe the program's key elements, notify them of plans to discuss the project

publicly, and provide them with a program description and outline of responses to any concerns about the program. By providing an explanation to supporters before the media spotlight hits, planners can ensure that the community will receive a consistent, collective set of information.

After contacting natural partners—human services advocates, health and social service providers, and sympathetic elected officials and religious leaders—veteran planners suggest seeking support from parent-teacher organizations or other community groups that may be willing to help with planning, public presentations, and additional community outreach. The core group of planners should expand to include these supporters before efforts to implement the program begin.

Use public forums to air the issues, but structure meetings carefully. Portland's planners designed forums in which elected officials listened to comments that were facilitated by community leaders who did not represent either the school district or the health department. By requiring speakers to state their names and addresses, facilitators limited testimony to actual residents of the district in which the clinic would be located—a strategy that prevented distortion of the extent of community concern. If the clinic is already operating, program leaders can build support by inviting partners or community members to tour the facility and become familiar with its services.

Strategic thinking about how to communicate plans for a school-health linkage, and to whom, is especially important if planners are trying to build a community base in a rural area, because the power of the individual is greater. In larger communities, organizers usually can build enough momentum to carry the plan through; but in a rural town, where there are fewer key players, one person's resistance can stop a project completely.

Develop a Proactive Media Approach

> *Strategies for working with the media are an alien concept for health departments. It's important to spend time thinking about them in advance, laying out the sequence of events....On the scale of media interest, from 1 to 10, teen health clinics tend to be a 12.*
>
> — School-based clinic planner

Unfortunately, many public agencies involved in health care do not have good systems for dealing with the media. And although media relations conducted by practitioners may be effective, it isn't practical because of staff time constraints. But projects that don't deal openly with the media often receive bad coverage because reporters focus on controversy instead of the benefits of services.

The core planning group should spend several months discussing program design until members understand how the community is likely to perceive each element. In some communities, merely proposing a school-based clinic may be controversial; in other areas, specific services may raise concerns. Work your way up the controversy scale, one veteran planner advised: Are you providing controversial reproductive health services? What protocols will you use for delivering services? Develop responses to each concern that community members might have.

What Services, Where, When, and to Whom?

The target group, location, and mix of services provided are core decisions around which school-linked and school-based programs are built. The impetus for the program, the composition of the planning group, the community needs assessment, and responses to public concerns discussed above all have a significant influence on decisions about the scope and location of services. Once the key players and

Additional Tips from the Field

- Anticipate community concerns. Hold public meetings; seek support from the superintendent of schools, county commissioners, and top health department administrators in addition to parents, teachers, and principals.

- Include media representatives on the program's advisory committee.

- View media relations as part of an organizing strategy. Look for support among community organizers who have public relations experience.

- Pick one or two credible, accessible planners to use as media representatives so your message to the community is consistent. Media contacts should serve as liaisons between reporters and sources within the planning group.

- Develop a few simple messages that support your program. Contact writers and editors to discuss your messages so they don't focus only on controversy.

- Be open to community concerns; present your ideas in terms of problems that need solutions, not as radical changes that you intend to enforce. "Never speak in absolutes, as if you have everything all figured out," advised one planner. "Always invite participation."

- Focus on positive aspects as well as controversy. "Don't be afraid to blow your own horn once you've done some good things," advises a physician. "Make sure the school district and the community know what you've done."

- Don't let controversy delay implementation. "There will be controversy—there's no way to avoid it," said one planner. "That doesn't mean you shouldn't do all the community development you can, but don't keep planning and planning until you think there's not going to be any controversy, because that day is not going to come."

interests are assembled and the needs assessment completed, planners can begin to consider the "nuts and bolts" questions:

- Who should be the target group(s)?
- Should services be limited to students, available to families, or open to communities?
- Should services be school-based or school-linked?
- What mix of medical, psychosocial, and dental services should be offered, at what time of day, and at what stage of the program?
- How should the health services be integrated with the education program?

Who is the Target Group?

Elementary, middle, or high school students? School-linked services exist in high schools, middle schools, and elementary schools, although high schools are the most common location for school-based health centers. School-linked services implemented at all three schooling levels in a community would facilitate continuity of access to services as children progress through school. This model is rare, however. This is in part due to funding constraints, but sites also may opt to concentrate on a single school level because each age group requires a different mix of services and raises somewhat different concerns.

There is growing interest in implementing school-linked and school-based services in elementary schools as a way to emphasize prevention. Many high-risk behaviors begin before students reach high school, making health-related interventions important in middle and elementary schools. In addition, parents play a larger role in children's lives in elementary and middle school and thus are likely to be more active in decisions around school-linked and school-based services. Concerns among parents about services in elementary schools tend to center on the extent to which their role in the care of their children is diminished. This has implications for procedures for obtaining parental involvement and consent, issues that are discussed in other sections of this book.

At the middle and high school levels, concerns emerge about reproductive health and sex education. Reservations among parents and community members tend to focus on family planning services and the extent to which providing such services at or through schools encourages sexual activity among students. Several sites consciously avoided middle schools in order to avoid controversy over family planning, and some high school health initiatives compromised on family planning services to keep the overall program afloat.

One exception is Portland, where in early 1995 the county health department expanded its school-based clinic program to two middle schools and one elementary school. Implementers found that middle- and elementary-school programs required a stronger effort to reach parents because consent is required for most services. Strategies included in-person or telephone contact with parents on a more regular basis than at the high school level, invitations to parents to attend appointments at the clinics, and placement of an outreach worker on the staff to make home visits if necessary. In addition, because students' attitudes are different at the elementary, middle, and high school levels, elementary- and middle-school clinic staff required training in working with younger clients, with an emphasis on preventing or diverting unhealthy behavior. Although these clinics have very recently begun implementation, observers predicted that they would also find a greater need for treatment of mental health and behavioral

problems than at the high school level because students with these problems would not yet have dropped out of school. On the other hand, medical staff expected that the smaller size of most elementary and middle schools would provide opportunities to get to know students better and to improve integration with school staff.

Income eligibility. Most school-linked and school-based programs offer services to all students, regardless of income. In part, this is possible because planners select schools with a high proportion of students from low-income families. It is also a deliberate effort to minimize the stigma associated with the services. One site with a school-linked health center battles a lingering public perception that it is a free clinic rather than a community clinic. Staff found that some potential clients did not consider using the services because they considered it only for "poor people." This is not a problem for programs such as mobile vans, which travel to communities that can't use the clinic because it is too far away.

Should the program serve students, families, or communities? All of the programs in the sample had a goal of improving health and/or access to health care to the entire student body of the target school(s). The differences in program design emerged in whether the program also served students' siblings, parents, or other community members not directly linked to students enrolled in the school(s). Again, initial goals and available resources are significant factors. In addition, however, programs consider the extent to which limiting the target population imposes a stigma on the services. Planners also consider the available pool of reimbursements and may choose to broaden their service population to include greater numbers of insured and Medicaid-eligible patients. The sample included a range of target populations:

- The Fort Pierce Family Service Center in Florida makes its services available to all family members
- The Cherry Street Health Services program in Michigan focuses entirely on the basic medical and dental needs of elementary students and provides no family services
- As the sole medical facility in its locality, Clinica Adelante in Arizona serves the entire community

Should Services be School-linked or School-based?

School-linked services are those medical and psychosocial services provided through special referral arrangements between schools and other agencies. A school-linked program may provide transportation to and from the school and other agencies, or establish special relationships with other providers that enable them to make appropriate referrals and schedule appointments on behalf of students and their families. These linkages target students with unmet health needs and ensure that they get to the services they need.

Programs are *school-based* if medical or psychosocial services are delivered on school grounds. Another term for this approach is *co-location of services*. While school-linked programs bring students to the services, school-based programs bring the services to the students by locating them within the existing school building or in a separate building on school grounds. The services may be available on a full- or part-time basis.

The degree to which a school-health program is linked to or located at a school can have a significant impact on the services it provides, the number of students and others who use the services, and the degree of collaboration among the school and health staff. Several sources indicated that, especially in high-need areas where increased access to care was a primary goal, the delivery of services at or very near schools was more desirable than simply facilitating referrals.

As a result, most of the sites have at least some school-based component. However, sources also recognized that the location of services should be responsive to the particular needs and concerns of the community.

Factors influencing location. For most of the programs profiled here, the decision to link or co-locate health services on school grounds was influenced by both practical and philosophical considerations. Some sites chose to co-locate services because funding became available with requirements that included building school-based health centers. In Florida, for example, a state initiative that provided funding specifically for school-based health services influenced program design. Other sites considered both options and weighed a variety of factors, discussed below.

The breadth of the target group, and the convenience of a location for those individuals, are key considerations in decisions about service location. Some sites are designed to serve not just students but also the broader community located near—but not within—schools. This allows them to attract and serve a larger proportion of the community while still improving children's access to care through school linkages. For example, a program in Fort Pierce, Florida is located on school grounds but leaders call the program school-linked because its goal is to connect students' entire families and other community members to health services.

School-based services, or services delivered very near the school site, also save students (and parents) from making extra trips to receive care. In some studies, students—especially adolescents—have reported that they would be much less likely to use a health center located too far off-campus, even if they were referred directly by a school nurse and transportation was provided. Thus a program in Blanca, Colorado locates health services at a community center across the street from the school building, and school staff work closely with health staff to ensure that students make it across the street to the health center. Convenience is a different matter in large rural areas, where schools may be no more convenient than other locations—especially for services provided before or after school hours or to other family members—and school-linked programs may make more sense. School busing presents a similar dilemma for school-based services in urban areas, because many students do not live near the schools they attend.

In some sites, the decision about location of services required addressing school concerns about the implications of school-based service delivery. School-based services impose demands for school resources and are potentially more disruptive to school operations than school-linked programs. School-linked programs can therefore be easier to initiate because they place fewer logistical demands and management responsibilities on schools. In particular, finding space for a school-based clinic can generate conflicts between school and clinic staff. Because many schools are strapped for space and do not have the resources to build additional space for health services, space can become a test of a school's commitment to the health program. "Some schools will say, 'We'll give you part of the teachers' lounge and two broom closets and a janitor for a month to see if this will work'—and other people stand there in their huge schools and say, 'We have no room at all,'" a health care administrator observed.

Even when schools are able and willing to provide space, the use of the space may cause disagreements. At one site, for example, school building regulations required that the health facility have three separate bathrooms—one for male clients, one for female clients, and one for staff. Clinic staff saw this as a tremendous waste of limited space in a building that is essentially a large trailer. Because the community health center sponsoring the services depends on revenue

generated by patient fees and Medicaid reimbursement, its staff saw the extra bathrooms as limiting their ability to maintain an efficient patient flow—and therefore as limiting their revenue. Locating, remodeling, and equipping space for a school-based program must be negotiated very early in the planning stage so that neither partner is surprised by hidden costs or logistical barriers. These issues are especially important because inadequate space will quickly lead to burnout among clinic staff.

Community concerns about the provision of services on school grounds also influence service location. In some cases, planners locate services off-site to ease community objections to expanding the role of the school. School-linked rather than school-based services can also be less threatening to parents, who may fear loss of involvement in their children's health care and health education. In other cases, planners decide that the convenience of school-based services, and the likelihood of increasing access to basic health services, is more important than the breadth of services.

Sites also considered the importance of fostering close interaction and cooperation among school and health staff when deciding where to locate services. School-based programs and health centers located very near schools facilitate personal interactions between school and health staff to obtain services for students and to resolve logistical or other problems as they arise. For example, the school nurse at one site attributes the strength of the school-health linkage to the proximity between the school, the health center that operates the clinic, and the family-oriented social service center. Families whose children use the clinic are already using the health center, so clinic staff know them; the short distance between facilities makes it easy to share resources and coordinate parents, teacher, and staff for consultations, and it reduces the amount of time students spend out of class.

State or local licensing requirements for health care facilities may also play a role in the decision about where to deliver services. For example, one state requires that all health care facilities maintain a certain minimum number of hours of operation and schedule and follow specific protocols for service delivery and supervision that are more difficult to meet in a school-based setting. According to the director of one school-linked program, such restrictions can discourage the design of innovative service delivery strategies such as school-based health centers and mobile health vans. These programs may need to start small or operate part-time initially to build support and credibility in the community and to demonstrate the demand for services. Once established, these programs can then draw additional funding to support full-fledged health and/or social service centers.

Some licensing requirements are linked to liability concerns, another significant consideration for school-based programs. Health care providers must be insured against malpractice lawsuits and follow specific protocols for practice and supervision. Most existing health care providers, such as C/MHCs, carry such insurance for their staff and have established the necessary protocols. These must be translatable to a school setting, however, and the dictates of malpractice laws may supersede other priorities in terms of what services are provided, where, and by whom. In particular, supervision of health care staff posted off-site, at schools, requires creative solutions for school-based programs. These strategies are described in a later section on staffing.

Finally, school-based programs must recognize that a clinic's location *within* a school affects how much it gets used and its relationship with other school services. At one site in the sample, the school-based health center began in a space shared by the school nurse, located on a busy floor that received a lot of student traffic.

After about five years, school administrators moved the clinic into the basement so the original space could be converted to classrooms. The new clinic afforded more privacy but was much smaller and no longer co-located with the school nurse, which made communication between the school and clinic health staffs more difficult. The clinic now receives consistently fewer patient visits per day than it did in its original location.

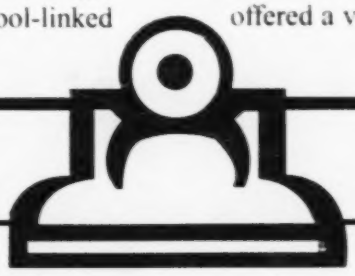
Blurring the lines between school-based and school-linked strategies. Most school-based programs are also school-linked—they provide services at the school as well as through special referral and/or transportation agreements. For example, one program in the sample has two major components—dental and basic medical care—provided through a cross between a school-based and a school-linked model. Two medical and three dental teams rotate among the seven targeted public schools. Each team sets up equipment in the school buildings and is school-based for three months, five days a week, before moving to another school.

Mobile vans are another mixed strategy, allowing both school-based and school-linked services. At a program in Konawa, Oklahoma, a mobile van travels to some schools but in other cases provides health care off school grounds because of community concerns about specific services.

Changing service locations over time. The choice of a school-linked or school-based service design is not necessarily permanent. Many programs that begin as linkages evolve into co-located programs as the need for services grows and changes, service partners work out the kinks in collaboration, funding becomes available, or the community observes the benefits and becomes more open to co-location of school and health services. The issues involved in modifying school-linked and school-based programs are discussed in Chapter 3.

What Mix of Services Should the Program Offer?

Ideally, school-based and school-linked services programs provide access to a continuum of health services for children and their families, by providing direct services, making referrals, and working to ensure that clients can and do keep referral appointments. Sites in the sample offered a variety of services ranging from basic



Additional Tips from the Field

- Even if you already have a philosophical preference for school-linked or school-based services, consider your community's needs, requirements, resources, and acceptance of or resistance to a particular mode of delivery. Make sure your program design responds realistically to these factors.

- It's better to start with a minor linkage than nothing at all. Once in place, a program can evolve in many directions.

services (e.g., health screenings, physical exams, immunizations, chronic illness care, health education, and minor acute care) to a comprehensive set of health services (e.g., basic care plus mental health counseling; case management; pregnancy testing and family planning; prenatal care; home visits; Head Start screenings; Women, Infants, and Children (WIC)/nutrition services; and dental care). Most sites try to balance preventive and acute care, although their ability to offer specialized services is limited by available resources, community preferences, and reimbursement policies. A typical set of services focuses on primary care and provides health screenings or physicals, immunizations, and minor acute care, with at least one additional specialized service such as family planning or dental care. (The services offered at each site in the sample are discussed in detail in Appendix D: Profiles of Selected Sites.)

Efforts to define "essential" or "core" services. In 1993, Columbia University's School Health Policy Initiative held two meetings of national experts and practitioners "to develop a national consensus on a minimum set of core services to be provided at school-based health centers in elementary, middle, and high schools."[5] Sponsored by the Centers for Disease Control and Prevention and The Carnegie Corporation of New York, the meetings generated a framework and principles for planning, implementing, and operating school-based health centers. The report of the meetings includes a set of checklists that define "essential," "optional preferred," and "optional as needed" services for health centers based in elementary, middle, and high schools. (See Appendix B.) In addition, the American School Health Association has endorsed eight components of a comprehensive school health program: (1) health instruction, (2) health services, (3) physical education, (4) guidance and counseling, (5) worksite health promotion for faculty and staff, (6) food service and nutritional information, (7) integration of school and community health efforts, and (8) efforts to promote a healthful school environment.[6]

Some of the most common services offered—sports physicals, screening and diagnostic services, and immunizations—are also those identified by principals, teachers, and school district administrators as most useful to schools. These services help schools fulfill basic health requirements for school registration, enrollment, and participation in school activities. For example:

- In Fort Pierce, Florida, the health center's ability to provide immunizations and physical exams for new students was immediately helpful to the school. In the past, many children were temporarily prevented from attending school because they had not met these requirements—but since the center opened, no students have been kept out of school for lack of immunizations.

- In Queen Creek, Arizona, schools and health centers have found a better way to serve the health needs of migrant students. Few of these students receive regular inoculations—and even if they did, their records would not be easily available. The health center across the street has been especially helpful in providing required screenings and immunizations to migrant students. This year, the school nurse will be able to maintain her own supply of vaccines, relieving the health center of this responsibility. The arrangement is a welcome reassignment of shared responsibilities for providing services to this population. The health

[5]Brellochs and Fothergill (1995). For full reference, see footnote on page 1.

[6]For more detail on these components, see: Allensworth, D.D., and Kolbe, L.J. (December 1987). The comprehensive school health program: Exploring an expanded concept. Journal of School Health, 57 (10), p. 410.

center can now focus more of its limited resources on other services, and the school nurse need not send students across the street for their shots.

Factors affecting the mix of services. According to sites, the ultimate mix and comprehensiveness of services depends on several factors, particularly the breadth of the original vision and goals of the program; the availability of staff, space, equipment, funding, or other resources; the level of commitment of both health and education partners; and the level of community support for specific services. The original motivation for the program, which usually arises from an identified need or problem in the community, influences at least the initial set of services included in the program's design. Initiatives launched to address specific problems such as high teen pregnancy rates or low immunization rates require specific services, while programs with a more general goal of improving access to preventive health care may require a broader set of services.

Hours of Operation

Hours of operation vary among sites. Several sites operate full-time health services on school grounds or make services available full-time through linkages during the school year, although only one site provides school-linked services year-round. Two sites extend services beyond school hours every day and into the early evening once a week, to facilitate appointments after school. Several sites provide services on limited days or for limited hours. One site offers services on school grounds in four two-hour sessions per week; another rotates medical teams to schools for three-month clinics.

Integrating Health Services with Education Programs

School-health programs whose services are integrated with the school's education program have the best chance of gaining support within a school because teachers and administrators become more aware of the services, more comfortable with health care providers, more understanding of health goals, and more inclined to communicate with clinic staff or refer students to the health center. Most of the programs in the sample integrate health services with the education programs, usually by providing health education in classrooms and during students' health appointments. Staff at most sites reported delivering classroom presentations on nutrition, sexually transmitted diseases, drug and alcohol abuse, self-esteem, and mental health. Clinic staff usually wait for teachers to request these services so they don't create turf issues—and sometimes health staff find it most effective to act as liaisons to other health care providers who might be more appropriate as presenters.

Both clinic and school sources say that the level of integration depends primarily on whether the school-health linkage has support from key school staff, especially the principal, teachers, or school nurse—so it's important to design strategies for achieving integration with these players. Several sites with school-based clinics held orientation meetings for all school staff when the program began, to explain the clinic's role within the school and to describe outreach services, such as classroom presentations, that would be available to teachers. To make their services more attractive to teachers, clinic staff tailored their efforts to the specific needs of individual classrooms—for example, teaching classmates of a diabetic student what to do if she became ill.

Classroom collaboration need not be limited to single presentations. At one urban site, the school-based clinic's mental health worker teaches a stress-reduction class in health classrooms and, with the clinic's nurse practitioner, implements a five-week curriculum on depression in a health class. A rural site with a smaller clinic staff makes health education presentations to high school physical education classes weekly for

nine weeks. The mobile van in Konawa, Oklahoma, provides a teen pregnancy prevention program that includes information on AIDS/HIV, STD prevention, reproductive biology, sexual responsibility, self-esteem, hygiene, and a separate birth control distribution service ranging from condom distribution to prescriptions. A sex education program for younger students deals with puberty changes, hygiene, self-esteem, and sexual abuse. Each school chooses which services to accept, although the AIDS/HIV component is mandated by the state.

Several sites have more extensive integration, bringing classes into the clinic for special presentations on a variety of topics or helping teachers design new health education curricula. At two sites, clinic and school staff viewed a health-related curriculum as a natural link with efforts to make the general curriculum more interdisciplinary and to promote hands-on learning. Similarly, a school with a comprehensive clinic in rural Colorado is changing its curriculum to include more practical applications and interdisciplinary learning; the principal says that health education services provided by the school clinic lend themselves to the hands-on teaching that educators want to promote.

Funding and Reimbursement

Given the variety of approaches to providing school-linked or school-based services, it is not surprising that the financing levels and strategies vary greatly among programs. But regardless of their approach, all programs face the challenge of obtaining enough funding to sustain the school-health linkage over the long term. To design a viable financing strategy, schools, community and migrant health centers, and other partners must develop strategies for sharing costs and must raise funds for planning and implementation. A major challenge for schools and C/MHCs is learning about and understanding one another's funding mechanisms and requirements. Each institution has its own funding sources, financing terminology, eligibility requirements, and "bottom line."

Funding Sources and Issues for C/MHCs

Community and migrant health centers are funded to provide services to Medicaid recipients, the uninsured, and other underserved populations in areas with few other health care resources. In addition to receiving federal grants, C/MHCs bill Medicaid, third-party payers (e.g., insurance companies), and patients themselves for services provided. Developing linkages between schools and C/MHCs offers school-based health centers the opportunity to tap the C/MHCs' capacity to bill Medicaid for services provided to schoolchildren. Two issues affect C/MHC Medicaid reimbursement: Medicaid requirements for providing services in schools, and the trend toward managed health care.

Medicaid. The major source of funding for basic health care services to low-income children is Medicaid.[7] Although the Medicaid eligibility requirements vary by state, every state is required to serve children who are (1) recipients of Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI); (2) infants under the age of 1 who are born to Medicaid-eligible women; (3) recipients of adoption assistance and foster care (funded under Title IV-E of the Social Security Act); (4) children under age 6 and pregnant women whose family income is at or below 133 percent of the federal poverty line; and (5) children under age 19 born after September 30, 1983 whose family income is at or below 100 percent of poverty.

In order for any service to be covered under the Medicaid state plan, it must be included among those listed in section 1905(c) of the

[7]Medicaid regulations have an impact on how and when the cost fo services provided in a school setting may be reimbursed. For more information, contact your state Medicaid agency (see Appendix C for a list of Medicaid directors).

Social Security Act. There is no benefit category in the Social Security Act titled "school-based services." Consequently, the state must describe its school-based services in terms of the specific 1905(a) services that will be provided. Except for services furnished under the EPSDT program (see below), a service must be specifically identified in the state's Medicaid plan to make Medicaid reimbursement available. Typically, schools that provide services offer several different Medicaid services. This means that the services must be separately identified and billed under each appropriate Medicaid coverage category (e.g., physical therapy, occupational therapy, rehabilitation, etc.). Service providers must meed the Medicaid provider qualification requirements for those services that are provided.

Within Medicaid, there is a preventive health program for Medicaid-eligible children and young adults under age 21, called the Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT). Services covered under EPSDT include screenings (comprehensive history, physical exam, immunizations, lab tests, and health education); dental, hearing, and vision services; and any other Medicaid-covered health service required to address a problem identified during the screenings.[8] Case management services to eligible children and families—including assistance in selecting a provider, assistance with transportation and scheduling appointments, follow-up and communication with parents to assure that services are received, service coordination, and outreach—may also be funded by EPSDT.

Before developing a strategy for conducting EPSDT outreach activities in the community, a school must first examine the state Medicaid plan and assess existing community outreach programs to prevent duplication of services.

Medicaid managed care. As the experience of several sites illustrates, managed care presents some obstacles to C/MHCs, especially in states with Medicaid managed-care initiatives that require Medicaid recipients to enroll in a health maintenance organization (HMO). In many Medicaid managed-care arrangements, HMOs are prepaid an amount of Medicaid money (called a "capitation payment") to cover the costs of providing health care services to the Medicaid recipients who enroll with that HMO. C/MHCs are sometimes not members of managed-care provider groups, however, and thus are not reimbursed through the capitation payment. Because Medicaid managed care is primarily a cost-containment rather than an access strategy, Medicaid-eligible clients may still turn to C/MHCs for care because they are more convenient or familiar. This leaves C/MHCs in Medicaid managed-care states with the option of either turning away Medicaid patients and hoping they visit their own HMO, or providing services with little hope of reimbursement from the patient's selected provider.

Funding Sources and Issues for Schools

Certain federal education programs support activities that relate to school-linked and school-based health programs.

Several Title I provisions relate to comprehensive services such as school-health linkages. Title I of the reauthorized Elementary and Secondary Education Act provides funds to improve the education of disadvantaged students. A school's eligibility for Title I funding is based on the percentage of low-income children living in a school's attendance area, usually measured by eligibility for free or reduced-price school lunches; often, these are the same students who most need school-linked health services. Schools can use Title I funding either for a comprehensive

[8]For more information on Medicaid and EPSDT, see U.S. Department of Health and Human Services, Health Care Financing Administration, Medicaid Bureau. (1992). EPSDT, A guide for educational programs. Washington, DC.

schoolwide program, which upgrades educational instructional services for all children, or for targeted assistance programs that reach the students at greatest risk of academic failure.

Title I schoolwide programs have several required components that may be used to support comprehensive service efforts, including (1) a comprehensive needs assessment of the entire school; (2) a reform plan developed with the involvement of community leaders, parents, and school staff; and (3) reform strategies that may include counseling or other pupil services. For example, Title I legislation stipulates that the needs assessment should examine how well students are performing in relation to state standards; based on that assessment, planners should design a schoolwide program to meet the students' needs. These programs are to be designed at the school level—not by the district. Although the legislation does not spell out the need to look at students' health, social, and emotional needs, a school assessment may find that these unmet needs prevent students from meeting state standards for learning. School-linked, coordinated services may be the solution that best responds to the needs identified by the Title I assessment.

Schools with Title I targeted assistance rograms have a special provision regarding the use of Title I funds for comprehensive services: If (1) health, nutrition, and other social services are not available to children being served by Title I funds, (2) the school has conducted a comprehensive needs assessment, and (3) funds are not available from any other source, then—only as a last resort—a portion of Title I funds can be used to provide basic medical equipment (e.g., eyeglasses and hearing aids), compensate a program coordinator, and provide training for teachers, parents, and school staff in identifying and meeting the comprehensive needs of children.

After a Title I program is implemented, if the school does not meet state goals for achievement within a prescribed period of time, the local education agency must provide technical assistance and may take corrective actions. These actions may include collaborative agreements between the school and other agencies to provide health and other social services needed to remove barriers to learning. Similarly, if a local education agency does not achieve the state's goals for achievement within a prescribed period of time, the state must provide technical assistance to the local agency. This can mean helping to establish collaborative agreements between the local education agency and other public agencies to provide health and other social services, and/or granting waivers of state laws or regulations that pose barriers to learning. In addition, the Title I plans submitted by local education agencies that obtain Title I funds must assure that the Title I programs will coordinate and collaborate with other agencies that provide services to children, youth, and families—including health care and social services.

Title I also has a program for schools with a large number of students who are the children of migratory agricultural workers and migratory fishers. The purpose of the migrant program is to establish and improve programs that meet the special educational needs of migrant children by helping states design programs to help these children overcome education disruption, cultural and language barriers, social isolation, health-related problems, and other factors that inhibit migrant children's ability to do well in school.[9]

[9]Certain restrictions apply to all Elementary and Secondary Education Act (ESEA) funds, including Title I funds. For example, Title XIV, Section 14511 of ESEA prohibits the use of any ESEA funds "(1) to develop or distribute materials, or operate programs or courses of instruction directed at youth, that are designed to promote or encourage sexual activity, whether homosexual or heterosexual; (2) to distribute or to aid in the distribution by any organization of legally obscene material to minors on school grounds; (3) to provide sex education or HIV prevention education in schools unless such instruction is age appropriate and includes the health benefits of abstinence; or (4) to operate a program of condom distribution in schools." Section 14511 also state the "Nothing in this section shall be construed to" authorize federal review or control of state, district, or school "instructional content, curriculum, and related activities" or to "require the distribution of scientifically or medically false or inaccurate materials or to prohibit the distribution of scientifically or medically true or accurate materials."

Other federal education programs are relevant to links between schools and service providers. Title XI of the reauthorized Elementary and Secondary Education Act allows schools and districts to allocate up to 5 percent of their total federal categorical funds to developing, implementing, or expanding a coordinated services project. Partners of projects using Title XI funds, who may include local education agencies, schools, or a consortium of schools, must create a development plan that assesses economic, social, and health barriers to educational achievement in the community; identifies ways to establish community partnerships that link public and private agencies; and uses funding for development for no longer than one year. The partners also must develop an implementation or expansion plan that provides results of a needs assessment; describes who will operate the project; describes project objectives, location, staffing, training, and evaluation; and provides information on the feasibility and use of a sliding fee scale for services.

Title XI funds may not be used for the direct provision of health or health-related services, but they may be used to hire a services coordinator, make minor renovations to existing buildings, purchase basic equipment, improve communications and information sharing, train teachers and other staff, and conduct the required needs assessments.[10]

Provisions of the Goals 2000: Educate America Act that relate to school-health linkages include a requirement that state plans focus on broad reforms, promote bottom-up improvement, facilitate flexibility and waivers from regulations that hinder reform, and involve parents and communities. Goals 2000 provides one-year subgrants to local education agencies for projects that focus on local reform and professional development; identify the critical health, nutrition, child care, and social service needs of students and families; and establish partnerships with public and private nonprofit agencies to increase family and student access to coordinated services at or near schools.

The Cost of Linkages Between Schools and Community and Migrant Health Centers

Most school-health programs we contacted, especially those that maintain more than one site but have a consolidated budget, were not able to give detailed budget information. Annual budgets among sites that could at least provide estimates of their costs ranged from approximately $100,000 to $300,000 a year, depending on the number of services provided, hours of operation, staffing arrangements, and the extent to which the services are school-linked or school-based. The bulk of these funds comes from a combination of resources contributed or solicited by schools and community health centers.

The following sample annual budgets indicate the range of costs for school-health services:

- Konawa Community Health Center spends $300,000 to operate a mobile van that visits schools in a very large, rural area. The program serves approximately 5,700 students a year.

- Three school-based health centers in urban Lancaster that operate eight hours a week cost a total of $123,000, an average of $41,000 per site. The site profiled for this book serves between 400 and 600 students a year.

- The Multnomah County Health Department, located in an urban setting, operated seven full-time school-based health centers and paid for the first six months of three new elementary- and

[10] Certain restrictions apply to all Elementary and Secondary Education Act funds, including Title XI funds. For example, the prohibitions of Sections 14511 (se previous footnote) apply to Title XI funds.

middle-school clinics for $2.2 million—an average cost per center of $261,400. The entire program serves more than 4,000 students; the site profiled for this book serves slightly more than 600 a year.

These costs are consistent with other studies that estimate that a typical budget for a full-time, school-based health center is $150,000, not including in-kind contributions.[11] Again, these numbers will vary with the size of the target population, breadth of services, and actual number of students served.

Typical Funding Combinations and Cost-Sharing Strategies

Funds to support the planning, implementation, and operation of school-linked and school-based health services come from both schools and health centers. Typically, the school system provides space or a facility for the health linkage, janitorial services, and utilities. The school also contributes staff time (e.g., school nurse, counselor, principal) for planning and for coordination between the school and the health program. The health care provider covers salaries for additional health staff (e.g., nurse practitioners, physicians, dentists, etc.), medical materials, and lab services. In addition, the health centers usually are responsible for billing Medicaid and private insurers for reimbursement. Staff salaries comprise the bulk of the costs, so the staffing mix required to deliver the desired set of services drives the ultimate size of the budget.

Just as schools and health centers share costs, they also share revenues and other resources. Southeast Lancaster Health Services, for example, shares with the school district half of all revenue that the health center receives as a result of services to students at the school clinic, in exchange for use of school facilities. The health center bills the school system (which administers the federal grant for the clinic) for staffing costs. (Staffing costs cannot exceed the grant amount, and no funds for the clinic come out of the school system's budget). At another site, a principal says his school benefits from access to office equipment that the school does not own—such as a fax machine—in the health program coordinator's office.

Typical sources of funding for school-health programs in the sample include:[12]

- Federal grants (usually Public Health Service Act sections 329, 330, or 340)
- State block grants, especially for maternal and child health
- Other special state grants (e.g., Florida's Full Service Schools grants)
- Local government funds
- Grants from national or local foundations or from local hospitals
- Medicaid reimbursement (primarily EPSDT)

Very few school health programs charge a fee for services, although two sites in the sample charged sliding fees based on family poverty level and the number of family members. Two sites draw from locally generated funds established to raise money for children's services. Fort Pierce has a local tax dedicated specifically to raising funds for children's services; Multnomah County draws the bulk of its support from the county general fund.

[11] Brellochs and Fothergill (1995)

[12] For local or regional contacts for funding information, see Appendix C.

As is true for any program, reliance on a single funding source is risky but hard to avoid, at least initially. Most sites draw from a single core source of funds and secure additional grants to support planning activities and specific services. For example:

- Clinica Adelante combines federal grants with a grant from a local foundation to pay for services and uses state Health Start funds to support a community out reach nurse—whose services are particularly important in this rural community, where migrant farm workers are often unfamiliar with and suspicious of public services

- Southeast Lancaster balances federal and state block grants (approximately 53 percent of the annual budget) with reimbursements from medical assistance (47 percent) to fund two school-based centers

- Valley Wide's school linkage receives 90 percent of its funding from federal grants and 10 percent from a state block grant

- Multnomah County's school-based health centers receive approximately 70 percent of their budget from county funds

- Konawa's school-linked mobile van was initially funded by a three-year, federal rural outreach start-up grant. Since the grant expired, the mobile van has been funded by patient revenue

- Fort Pierce's family service center receives approximately one-third of its funding from a state Full Service Schools grant. Staff and consumable supplies are funded by each agency co-located at the center; the grant helps defer the cost of maintaining the building, setup expenses, and the salary of the coordinator.

Some funding streams come with restrictions that affect a health program's design. In the Portland program's early years, for example, state funding for school-based clinics was available but the state was wary of controversy surrounding family planning and discouraged programs that would provide these services. Since family planning services comprised a major part of the Multnomah County Health Department's plan, this site sought funding from the county instead. In Konawa, funding from the Healthy People 2000 program requires that the health center focus on preventive care. Funding for the mobile van, which provides acute care, had to come from somewhere else. At Clinica Adelante, schools are not allowed to dedicate education funds to the linkage because the community believes that academic and social service roles should be separate. Medicaid reimbursements raise confidentiality problems at all sites because statements that reveal private information go to students' homes.

To meet their budgetary requirements, sites in the sample relied heavily on short-term or start-up grant funding and usually received the majority of their funding from a single source—conditions that leave them continually seeking new funding sources and threaten their long-term viability. The ability to obtain reimbursement from Medicaid, private insurers, and managed care organizations is crucial to long-term financing and is discussed in Chapter 3.

Other Funding Sources to Explore

The additional federal funding opportunities outlined below are important sources for school-linked programs to explore, although they were not used by sites in the sample. Some funds are administered through federal and state health agencies, others through the educational system, and a few by other human services agencies such as the Departments of Justice and Housing and Urban Development.

Federal health programs. The federal Maternal and Child Health Block Grant (Title V of the Public Health Services Act) is a common source of funds for school-based and school-linked health services. Title V funds are distributed as block grants to states, which are then responsible for awarding grants to local health departments and/or other maternal and child health agencies. Services provided under Title V include perinatal care and preventive and primary care for pregnant women, children, and adolescents.

In addition to funding community and migrant health centers, the Health Resources and Services Administration's Bureau of Primary Health Care also funds a variety of other programs for special populations. The programs most directly relevant to school-based and school-linked health services include:

- **The Comprehensive Perinatal Care Program** to improve pregnancy outcomes and health status of mothers and infants in neighborhoods served by C/MHCs

- **The Healthy Schools, Healthy Communities Program** to support school-based health programs for high risk students

- **The Health Care for the Homeless Program**, funded by the Stewart B. McKinney Homeless Assistance Act of 1987, to improve access to health care and substance abuse treatment for homeless individuals and families. **The Outreach and Primary Health Services for Homeless Children Program,** added to the McKinney Act in 1990, awards grants for comprehensive primary health care programs for homeless or near homeless children.

- **The Public Housing Primary Care Program**, which supports health centers located at or near public housing developments

Other federal human services initiatives. Several other federal agencies sponsor programs that meet the goals of school-linked and school-based services initiatives. Planners should explore these sources and the status of existing programs in their communities funded under these initiatives:

- **PACT (Pulling America's Cities Together)**, is a pilot program currently funded by the Department of Justice in five cities. It is a locally planned and operated initiative that brings together the strengths and resources of these communities to meet local needs, including educational and health needs.

- **The Family Preservation and Support Program** is funded by the U.S. Department of Health and Human Services and supports state efforts to improve the well-being of vulnerable children and their families, particularly those experiencing or at risk of abuse and neglect. States are encouraged to use this program as a catalyst for establishing a continuum of coordinated, integrated, culturally relevant, and family-focused services. Services range from preventive efforts to strengthen families by providing crucial support to services for families in serious crisis or at risk of having children removed from the home.

- **The Violent Crime Control and Law Enforcement Act of 1994** contains funding for efforts to prevent crime and violence among children and youth and in communities. The Ounce of Prevention Council, established by the Act,

coordinates crime prevention programs, including many oriented toward youth. The Community Schools provision, administered by the Department of Health and Human Services, provides funding for supervised after-school, weekend, and summer programs. The Family and Communities Endeavor Schools (FACES) program, administered by the Department of Education, supports in-school and after-school activities.

- **The Empowerment Zone/Enterprise Community Initiative**, administered by the Departments of Housing and Urban Development and Agriculture, creates community development compacts between the federal government and communities and state and local governments. Each compact includes a comprehensive, strategic plan for change, with performance-based benchmarks. Nine communities have been designated Empowerment Zones; six urban zones were awarded $100 million each, and three rural zones $40 million. Two urban areas were designated Supplemental Empowerment Zones (one for $125 million and one for $90 million). Ninety-one communities were designated Enterprise Communities and awarded $3 million. Four communities received Enhanced Enterprise Community awards of $25 million each.

Budget Checklist

Major budget items to consider:	Estimated Cost/Amount:	Potential funding sources:
Planning		
Community needs assessments		
Focus groups		
Public opinion polling		
Staff time		
Printing costs		
Child care costs for staff		
Development		
Building/modifying space for services if necessary		
Exam rooms		
Bathrooms		
Offices		
Obtaining equipment (medical and administrative)		
Operation		
Janitorial services		
Transportation services		
Utilities		
Telephones and Fax machines		
Supplies/materials		
Linked computer systems for information management		
Staff salaries		

Sources of Funds

Foundations _____
Local government _____
State grants _____
Federal grants _____
School district _____
Local service clubs _____
Local businesses _____
Private insurers/health maintenance organizations _____
Medicaid _____

Sample Budget

The following sample list of expenditures (for the 1994 fiscal year) was provided by a free-standing, school-linked adolescent health clinic in a large, metropolitan area. In 1994, this clinic served 1,029 students at a cost of $227 per client or $53 per visit. The funding source is the city's general fund.

Expense	Expenditure
Full-time employees	44,310
Part-time employees	127,689
Social security	12,726
Retirement contributions	4,943
Group life insurance	143
Hospitalization medical plans	3,285
Long-term disability group insurance	202
Personnel services subtotal:	**193,298**
Fees for professional services	21
Fees for temporary personnel services	1,566
Professional health services	5,151
Other equipment maintenance	305
Building and improvement maintenance	10,478
Photocopying	32
Printing	115
Office supplies	1,057
Food supplies	105
Housekeeping and janitorial supplies	2
Operating supplies and materials	383
Tools and shop supplies	55
Medical and laboratory supplies	10,965
Controlled operational equipment	433
Utilities - electric	1,717
Postal and messenger services	450
Telecommunications	5,463
Memberships/subscriptions/books	1,362
Conferences and registrations	660
Regional travel	383
Non-personnel expenditures subtotal:	**40,703**
TOTAL EXPENDITURES:	**$234,001**

Staffing Configurations, Roles, and Issues

Staffing arrangements at sites in the sample varied according to the programs' size, management structure, and comprehensiveness—ranging from one nurse or physician assistant working with one counselor or school nurse to a six-member staff including a pediatrician, two nurses, mental health counselors, and an administrative assistant. But whatever their configuration, sources at most sites identified similar staffing roles and issues involving key staff positions, hiring obstacles, necessary qualifications and experience, relationships with school nurses, coordination among education and health staff, supervision systems, and professional development needs.

Key Staff Positions and Roles

All sites have a full-time, site-based leader who often plays multiple roles and has extensive responsibilities for operating the program, seeing and treating clients, and sometimes coordinating with school staff or administrators. Our sources emphasized that this staff person should be located on site, either at a school-based clinic or at the point of contact for the school linkage, during as many hours of operation as possible in order to maintain program consistency. This key staff person usually is a nurse practitioner or physician assistant who is qualified to examine students, make diagnoses, prescribe treatment, and oversee licensed practical nurses (LPNs) on staff. Some sites, particularly those with comprehensive services or extensive integration with the education program, or those that are affiliated with larger reform efforts or family service centers, also have a coordinator to act as a liaison with school staff and other care providers. This liaison usually is also located on site but may not work full-time.

The nurse practitioners or physician assistants work very closely with the LPNs, school nurses, or community health nurses, who may work full-time or part-time to provide immunizations, take medical histories, determine medical priorities among students, and sometimes coordinate appointments. At all sites, communication between staff is constant and direct; because working quarters are often tight and staff must coordinate their efforts to meet the demand for services, staff at most sites said they promote a team atmosphere in which there is little or no hierarchy.

Many sites supplement core staff with people who provide more targeted services. For example, Clinica Adelante coordinates with lay health workers, provided by a state-funded prenatal education program, who make home visits to pregnant women and families with young children. Several rural sites supplement their staff with student nursing or mental health interns from local universities or community colleges, who are supervised by the regular nurse practitioners; however, some sites reported difficulties with attracting student interns, and no sites depended on student interns as a source of staffing.

About half of the sites in the sample rotated some or all of their staff among school or health center sites. This strategy allows programs to reach more clients but means that certain staff—and therefore certain services—are not available at all sites at all times. Schools that have a school-based clinic for a limited number of hours each week can solve scheduling gaps by relying on the school nurse to see students and make referrals to the health center when the clinic is closed.

Most programs have some mental health staff, usually counselors provided by the school district or an outside provider that coordinates with the health center. However, sources at all sites said mental health services are among their highest needs and that most school-health linkages lack sufficient mental health staff.

Although most sites choose staff carefully to ensure that students feel comfortable talking to any available staff person, certain staff positions seem

to have special strengths. Students at a comprehensive, urban site prefer to see the clinic coordinator first so they don't have to discuss their problems at the busy front desk, sources reported. At another school-based clinic where health center staff are not on site every day, clinic staff defer to the school nurse's judgment in making appointments because she is more familiar with students and their use of services.

Obstacles to Hiring Appropriate School-based Staff

Finding appropriate medical staff—people who have experience working with school-age children and youth and who are willing to work for less salary than they could command in similar positions in private health care—can be very difficult for school-linked and school-based health programs. The location of school health programs in extremely rural or high-crime, inner-city areas also makes it hard to attract and maintain staff. Many students who use the school clinics are emotionally needy; working with them is draining and takes a toll on staff. School-based health professionals need strong negotiating skills in order to juggle the needs of school, health provider, and school district bureaucracies and bring the groups together. And some health practitioners, accustomed to working among peers or with constant supervision, or who want more exposure or recognition, can find themselves feeling isolated at school sites.

Community and migrant health centers often solve staffing problems, at least partially, by staffing school health programs with practitioners from their own centers. But locating some health staff at the school might reduce the amount of time they can provide services at the main clinic. At one site, planners decided that, because they would be serving students in two medically underserved areas of the community, they would probably be seeing the same patients—just at a different, more accessible site—and therefore would not be increasing demands on staff time. In addition, planners realized that Medicaid reimburses at the same rate for office visits at a school and for visits to a health center—so they did not expect their income to be affected.

Issues in rural areas. School-linked health programs in rural areas may have an especially hard time attracting staff. Konawa, Oklahoma, for example, tried several strategies to locate staff for a school-linked program. Local business owners first attracted a physician to the area in 1964, by forming a non-profit organization that provided loans to a medical student. After graduating, the new doctor practiced in Konawa for five years, working at a clinic built by the local utility company. When the doctor moved to another community to open his own practice, Konawa replaced him with a succession of phusicians, each of whom stayed for only one or two years. At times, the clinic had to operate without a medical director or with only part-time services. Konawa's community health center opened in 1984; physicians hired by the health center, most of whom are identified through the federal medical school loan repayment program, continue to move on about every two years. Administrators trace the frequent turnover to two factors: (1) serving such a large population produces burnout, and (2) many physicians can earn more by starting their own practices (although in recent years the clinic's salaries have become more competitive.)

Other rural programs that establish satellite clinics find it hard to satisfy health care practitioners who find their experience and peer interaction limited at the school sites. Clinica Adelante's main clinic, located more than an hour away from its satellite, must balance providing adequate support and monitoring with allowing clinic staff the freedom to tailor their services and strategies to community needs. The nurse practitioner at the satellite clinic assumes certain administrative functions by default, and must juggle this role with a busy medical practice. To mitigate potential staff problems in this setting, Clinica Adelante's program director has learned

to screen job candidates carefully for the ability and desire to be flexible, adaptive, politically astute, and entrepreneurial. In addition, the nurse practitioner spends one day a month at the main health center to maintain her skills, an arrangement she insisted upon as a condition of working in Queen Creek full time. Tensions between the main health center and the satellite clinic linger, however, and to some extent are inevitable as the satellites receive pressure to become self-supporting.

Screening out unrealistic expectations. Programs that have the backing of a large infrastructure—such as the Multnomah County Health Department's school-based clinics—find they have the greatest success finding compatible school-health staff when they select people from within their own organization. This isn't a fail-safe strategy, however. A health department administrator says that although many health professionals want to transfer into the school clinic program because they expect to find more autonomy, they don't realize that they will encounter some bureaucracy at the school level. "I've had [staff] say, why can't we dispense [birth control pills] on-site—we're a county program," the administrator said. "They have to realize we're really guests." For this reason, some planners suggest observing job candidates working in a school clinic setting before hiring. This way, job candidates are exposed to the real experiences they will encounter in the schools, and program leaders can make sure the candidate doesn't have an idealized vision of the job.

The Impact of Staff Qualifications and Previous Experience

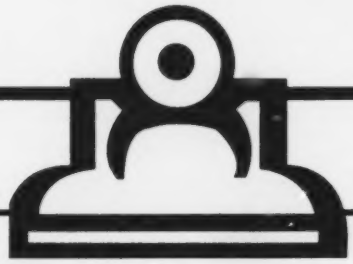
Because schools are significantly different institutions than health centers, and because students may need a different combination of service strategies than other health care clients, school-health programs place a premium on staff who are comfortable working with children or adolescents and experienced in working with school-age clients. With few exceptions, all of the staff at sites in the sample had backgrounds in pediatric or adolescent health care. The physician assistants, nurse practitioners, and LPNs at these sites had degrees in pediatric and adolescent health or specializations in primary care, prenatal care, pediatric mental health, family planning, or family nursing.

School-linked health staff who like to work with students often integrate their health promotion efforts with education in ways that benefit both sides. For example, the physician assistant at a rural site serves on the local school board, which gives her credibility with educators and access to both education and health perspectives. The nurse practitioner at another rural site doubles as a coach for the school's soccer team, which increases her contact with students, families, and school staff. Hiring staff who are comfortable having contact with schools and students helps make a school-health program more appealing to students; staff have to be extra-responsive to students' inquiries in order to gain their trust. "We still get lots of phone calls from kids who graduated years ago who feel we're the only person they can ask a question of," says one school-based clinic nurse.

Orienting New Staff

Even staff with appropriate experience face an adjustment when they first begin working in schools. Some of the longer-running sites in the sample solved this problem by providing orientation to all new staff. Orientation topics and resources in Portland included the following:

Topic	Resource Materials
Overview of school-based health clinics • history, philosophy, mission, goals, objectives • self-managed work team concepts • organizational chart • meeting schedule • supervisory structure • staffing, staff evaluations	Article on school-based health clinics Annual report for health clinics Written mission, goals, objectives Workbook for self-managed work teams Policy and procedure notebook Team job descriptions Health center and school district calendars
School site orientation • meet principal and key school personnel: health teachers, school counselor, secretaries, administrators • review school policies, procedures, faculty meeting schedule • tour facility • overview of school organizations: PTA, site council, school interdisciplinary team, community schools program, other special programs in schools • overview of English as a Second Language (ESL)/special ed./alternative programs	School policy and procedure manual Meetings and observation time at school; may include lunch or bus duty, classroom observation, sitting with school secretary, or participating in faculty and interdisciplinary team meetings
Off-campus orientation • Visit other school-based clinics, local family or community resource centers, local primary care health center, other youth-serving organizations	
Working with school personnel	Written agreement between clinics, school staff Set up process for resolving problems
School-based clinic facility and operations • equipment/supplies, including phones, keys, etc. • hours of operation • pharmacy arrangements, laboratory • referrals outside school-based clinic • insurance billing • consent/confidentiality • reproductive issues	
Medical records and data collection • medical record forms and codes, brochures, consent process, insurance, health/social histories	Sample chart with all appropriate forms
Grant requirements, goals, and objectives • reporting, data system, advisory board	



Additional Tips from the Field

- Screen staff carefully to find people who can deal with autonomy; show flexibility; and have management, political, and entrepreneurial skills as well as clinical skills.

- Make sure your program has strong leadership that can keep a network of community resources together and functioning as a team.

Coordinating Health Staff with School Nurses

Coordination with the school nurse, if one exists, is essential to building support among school staff and administrators and averting turf problems. "She is the gatekeeper in the school system," explained one health center director; "the school nurse can make or break this program." At most sites in the sample that had both school-based clinics and school nurses, the nurses had daily contact with the clinics either by phone or in person, and in some cases were located within the clinic. A typical strategy for promoting coordination was to make the school nurse the students' first contact with the clinic so she could assess medical priorities among students and make or accept referrals to and from the clinic.

Coordinating referrals. At school-linked sites, coordination with the school nurse is especially important if she or he is responsible for referrals to the health center. At Clinica Adelante in Arizona, for example, the school district nurse, the high school principal, and the clinic's nurse practitioner work particularly closely. School staff usually refer students first to the school nurse and depend on her to make referrals to the clinic. The school nurse follows up to ensure that students get to the clinic—but whether services such as immunizations are provided solely by the school nurse on school grounds, by clinic staff on school grounds, or at an off-site clinic depends on the child's needs and the capacity of the school nurse.

Careful coordination between a health center's care providers and school nurses can solve or avert problems that would otherwise derail a school-health linkage; poor coordination can be disastrous. At one urban site in the sample, turf issues arose between public health staff and a school nurse when the health staff first began providing comprehensive, school-based services to high school students without consulting school nurses, and the school nurse worried that her role would diminish. The site solved the problem by establishing a process for referrals between the health care providers and by arranging for the school nurse to examine some patients in the new clinic.

Defining separate roles. Coordination between health center staff and school nurses improves when the two parties make an effort to establish separate roles for each other, instead of competing to serve the same patients. For example, an urban site that experienced turf problems arranged to have the school nurse serve walk-in clients, provide case management of chronic physical problems, and assess medical priorities among students for the health center while the school-based clinic provides long-term, appointment-oriented health care, medication administered on-site, and prescriptions. The region's director of school health services compares the school nurse's office under this setup to an emergency clinic, while the school-based clinic operates like a doctor's office. At this site, the nurse refers one-third to one-fourth of the students she sees every day to the clinic. This system has worked to the benefit of students as well as staff. For example, the school nurse diagnosed a chronic ear infection in a special education student with poor communication skills but was not allowed to prescribe antibiotics under district regulations. The nurse referred the student to the clinic, where staff prescribed medication and referred the student for surgery on a perforated ear drum. This site facilitates interaction between the school nurse and clinic staff through special referral forms. When the school nurse wants to refer a student to the clinic, she fills out a one-page form that gives preliminary medical and parental consent information, allows the school nurse and clinic staff to share information, and includes space for feedback from the clinic to the school nurse on any diagnosis, treatment, or followup plans. (See Appendix B for sample referral forms.)

Addressing school nurses' concerns. Even with a carefully designed coordination system, integrating the efforts of school-health programs with school nurse programs requires frequent attention. The main issues are (1) concern that clinic staff will take on all of school nurses' responsibilities and roles in the schools and (2) confusion among students and teachers over the difference between clinic and school nurse roles. One site in the sample painstakingly worked out compromises between school nurses and clinic staff at high schools, only to have the same concerns about the loss of school nurse responsibilities resurface many years later when the school-based health program expanded to middle and elementary schools.

Concerns became so great at one site that school nurses filed a grievance against the public school system, accusing the district of subcontracting services that could be provided by the school nurses. The nurses feared that their role would be phased out if the cash-strapped school system could get community clinics to pay for health services. They were also worried that the clinic staff covered by the community health center's liability insurance were legally able to provide more comprehensive services. However, a judge ruled that the health center nurses provided different, nonduplicated services; nurses from both institution have subsequently worked to improve their relationship by creating joint projects, such as a school health fair.

Coordinating School and Health Staff

No matter how similar their goals may be at times, schools and health centers operate in different cultures, with different practices. This can create frustration on both sides. Health centers are businesses; schools are not. Schools want clinics to supplement education but not to interfere with it, while health professionals protest that schools are accustomed to operating without specific productivity standards or accountability. Health staff, on the other hand, have a hard time understanding the intense political environment of the typical school system, where principals and other administrators can be transferred if their activities displease parents, the community, or the school system.

Designing a health program that coordinates school and health staff effectively, on a daily basis, depends to some extent on the personalities and inclinations of the people involved. At times, sources described principals, health educators, classroom teachers, district administrators, and school board members as *most* supportive of coordination with health services. At other times, people in these same positions were labeled *least* supportive. In all cases, however, sources emphasized that the principal's support is essential to establishing strong coordination because of the central role a principal plays within the school. "Principals are kings and queens in their fiefdoms," said a health administrator who planned one school-health linkage, "...whereas clinics don't have as much power to decide what they want to do."

Good coordination doesn't just happen. It requires good communication; a willingness to interact to solve problems; shared goals among clinic staff, teachers, and school administrators; and, sometimes, protocols for dealing with touchy issues. These factors may not come into play every day—but when issues arise that test links between a school and health center, they can't be avoided.

Establishing mutual understanding. Designing a school-health linkage that has good coordination between school and health staff means placing an emphasis on strategies that establish rapport between staff members. Coordination of efforts doesn't always come naturally and may make some staff uncomfortable. "Schools are just like a foreign country [to health care providers]," says a health program administrator. "When you get mutual understanding,

The Impact of Good Coordination Between School and Health Staff

In one urban site where clinic staff maintain close contact with school administrators, health providers at a school-based clinic faced a dilemma when a student who had been receiving care was expelled from school and thus lost his only access to health care. By communicating this concern to the principal and establishing that both educators and health providers had the student's best interests in mind, clinic staff were able to coordinate short-term medical treatment for the student until a new source could be found.

The impact of coordination on this student's life is obvious—but the coordination also benefits the health program. Because of these and other coordinated efforts, staff at that school are forming a more active partnership with the clinic and no longer view it as an outside entity that is simply co-located in the school. Teachers now view the clinic's services as a way to broaden the impact of classroom discussions on social issues such as AIDS or teen pregnancy.

things like space and policies about who can be out of class when, and all those issues, begin to fall into place. It doesn't mean they go away, but at least you have a common goal."

To reach mutual understanding, leaders on both sides must believe that an integrated social services/health program fits logically into the educational scheme. Teachers at most sites reported some resistance to school-linked health services among some of their peers, especially when students must miss class time in order to visit the clinic. Although all clinics try to schedule as many appointments as possible before or after school or during non-academic periods, because of the high number of students needing services this is not always possible—especially for students who need to visit the clinic repeatedly (e.g., for mental health counseling).

Clinic staff often take the initiative for developing support among teachers and school staff. In Portland, clinic staff found supporters among physical education teachers—many of whom had been in place a long time and quickly "adopted" the new clinic staff—and coaches,

Teachers and Clinic Staff Must Share Realistic Expectations for a School-linked Program

Teachers at one site, impressed by the success of their school-based health center, expected that they could send difficult children to the center's physician to be "fixed" through prescriptions for Ritalin or other behavior-modifying medications—despite the fact that the children's problems were not always caused by medical disorders. The clinic's site coordinator and the principal addressed the problem by increasing communication between teachers and clinic staff so the health practitioners could hear teachers' concerns about student behavior and teachers could build their knowledge about appropriate medical treatments. Clinic staff were invited to eat lunch in the school cafeteria and use the teacher's lounge for breaks to increase informal interaction; teachers whose students receive medical services were encouraged to meet weekly with clinic staff to discuss progress and setbacks.

In one case, school staff referred a student to the school-based health center, hoping that he would receive Ritalin to control his behavior. The child's mother resisted the school's diagnosis, and the clinic's physician agreed that Ritalin was unnecessary in this case; mental health counselors said the child was depressed and prescribed antidepressants. When the child returned to school but continued to misbehave, school staff assumed that the mother had not followed their recommendations. The mother, confused and frustrated, asked clinic staff to meet with school staff to explain the child's diagnosis, treatment plan, and prognosis. Now, each party has similar expectations and the child's behavior is improving.

who were eager to set up appointments for sports physicals. Teachers, who were well aware that many students lived in poverty and had limited access to health care, also were quick to support the clinic. Clinic staff cultivated school support by maintaining high visibility: walking around the halls, eating in the cafeteria with students, attending afterschool sports events, making classroom presentations, and helping teachers with their health curricula or special concerns. To show their involvement with the whole school, clinic staff wore the school colors on game days, attended assemblies, and held raffles to encourage students to sign up for basic services. These activities also raised awareness about the services available at the clinics. At the same time, clinic staff made a point of showing their respect for other teachers by not letting students loiter in the clinic when they were supposed to be in class.

An Example of Close Coordination Among School and Clinic Staff

Although it has no formal structure, the relationship between school and clinic staff at Clinica Adelante is so close that when the clinic was asked to make a presentation at a state conference on school-linked services, the nurse practitioner and community health nurse shared the platform with the high school principal, school nurse, and district superintendent, who all contributed to the discussion.

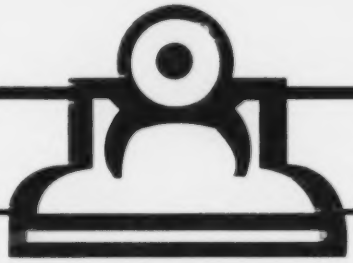
The school nurse, who serves three schools in the district, approached clinic staff soon after she was hired to establish a relationship; recently, she arranged to maintain her own supply of vaccines and administer them at the schools to relieve the clinic of some of its immunization workload. The high school principal, who is also the director of the family resource center, coordinates with clinic staff and makes many referrals to the clinic. The high school counselor coordinates her services with the clinic's psychiatric nurse practitioner intern.

The high school principal and counselor recognized the critical role of teachers as the adults most likely to identify students' needs and link them to the health center. To assist teachers in this role, the principal and counselor established and trained teams of teachers and other school staff to identify and address the needs of students at risk of school failure. Participants receive three days of training that focuses on (1) general knowledge about risk factors, (2) approaching students about sensitive issues, (3) making referrals, and (4) facilitating counseling sessions. These staff members now intervene throughout the school to help students with personal and family problems that affect school attendance and performance. (Clinic personnel were not involved in this training.)

Compromises support coordination on both sides. Good coordination requires a willingness to compromise so that both the education and health programs can be as strong as possible. For example, an urban school developed a pass system to address teachers' concerns that students would use the health center to get out of class unnecessarily. Every student receives a pass that allows him or her to leave class four times per quarter to visit the nurse, clinic, restroom, or a locker. Unfortunately, the limited number of visits allowed makes it hard to schedule repeated visits for chronic health needs. The problem is aggravated at this and other sites by the fact that the students who most need health services are often the ones who are farthest behind academically, so teachers are understandably reluctant to release them to attend other programs. Now, students who make appointments at the health clinic also receive a slip that verifies the appointment. The day before the appointment, the clinic notifies the teacher of the class during which each visit will occur. When the student must leave for the appointment, he or she gives the slip to the teacher. This system has been so successful that some teachers who receive notification of future appointments now call the clinic to tell staff when the student in question is suspended or absent. At another site, where a clinic sets up once a week in the closet and hallway of a storefront alternative school, teachers compromise by showing instructional films during clinic hours to minimize disruptions.

Program designers must realize that school staff sometimes have good reasons for resisting coordination with health services, however. For example, in an effort to save the schools money, one rural clinic's medical director suggested that his staff teach teachers how to check students for lice so they wouldn't have to contact nurses for this service. But schools were concerned that parents would be angry with teachers for finding lice in their children's hair, and declined.

Scheduling barriers can limit opportunities for coordination. Scheduling often poses a barrier to school-clinic coordination because schools and clinics operate at different times. It may be hard to bring teachers, administrators, and clinic staff together for meetings—and, although the neediest students often arrive at school long before the school day starts and want to see clinic staff, custodians may not arrive early to open the school. Schools that use block scheduling to increase learning time encounter barriers, too; teachers at one site asked the clinic not to interrupt their 90-minute blocks with phone calls except during the first or last five minutes of each class period—making it difficult



Additional Tips from the Field

- Attitude is important if you want to gain acceptance from a school. "You can't go in with the attitude that you know all the answers; school nurses have often been doing their job for a long time and they know a lot," said a clinic physician. "I defer to [her] knowledge about the students in terms of which ones are [frequently ill]. She knows which teachers hardly ever send students down, and which ones send them at the drop of a hat.... [You] need the attitude that we're going to work as a team."

- Emphasize communication among service providers and school administrators and staff. Develop trust and cooperation so the groups focus on the families they serve, rather than on the various agencies. Make sure that each player has a realistic understanding of what a school-linked health facility can do.

- Realize that when schools deal with outside agencies, they may also take on the agencies' internal struggles. Understanding the pressures on clinic staff helps coordinating efforts on a daily basis.

for clinic staff to contact students and teachers. "It helps to know in advance that the clinic's hours may be different from the school's so you can negotiate in advance who will have keys or access to what [space]," and so clinic staff can set up systems for locking up appointment books and medical files so they aren't accessible to cleaning crews, one planner said.

Staff Supervision Systems

School-based health programs in the sample had a great deal of autonomy over daily practices, with supervision provided by off-site physicians or medical directors based at the community or migrant health centers who review clinic staff's notes and diagnoses periodically and are available for telephone consultations if needed. These supervisors usually receive weekly reports from the clinic staff or visit the site weekly or monthly. Staff at school-linked programs may be supervised by physicians on site if the services occur at a community or family center, or by periodic oversight similar to that of school-based clinics if the program uses a mobile van. In all cases, supervisors showed high levels of trust for the work done by front-line practitioners, who were free to perform as many services as they were qualified and certified to conduct—and with physicians formally signing off on procedures only when required for Medicaid reimbursement. This level of trust is important for

school-health linkages because it enables them to operate with small staffs, maintain close working relationships, and provide many services efficiently.

Physicians who supervise the health staff in school-health programs do not usually extend their oversight to school nurses, but sources did not consider this a problem because the nurses, when available, were integrated into the school-health linkage and communication among nurses and other staff members kept all players well informed of the others' activities. However, we did find instances in which school and health administrators disagreed over which entity should have direct oversight of the program and staff. The disagreements usually were caused by personality conflicts rather than by faulty supervisory systems. For example, a principal whose school has an on-site health clinic wanted full control over the clinic's operations and staff because he saw it as a part of "his" school—but the health center that operates the clinic has a contract with the school system that grants it autonomous control over the clinic and services. Unfortunately, clinic staff, who are accountable only to the health center, sometimes feel trapped between the school and the health center.

Programs that involve services at several sites find it useful to combine supervisory activities to streamline their efforts and to provide cohesion among sites. In Portland, where the county health department operates clinics in seven high schools, a lead nurse practitioner from the health department visits all clinics regularly to evaluate staff. In addition, the on-site coordinator (also a community health nurse) at each site visits other clinics to observe their activities and help solve problems.

Professional Development

Front-line clinic staff view professional development as extremely important in order to help staff maintain the medical skills they typically don't use at a school site and learn how to address needs that arise in the student population but are not part of standard health care training. Most programs we studied offered some form of professional development, usually through the health center rather than the school district. Typically, clinic staff can and do attend local or regional training seminars or forums.

Affiliation with County Health Organizations Increases a School-based Program's Access to Funds for Professional Development

In Portland, where the school-based clinics are operated by the county health department, clinic staff participate in monthly peer forums, attend nursing forums on such topics as domestic violence, and attend lectures on topics such as developing self-directed work teams. Nurses in these programs also have attended forums on adolescent reproductive health care, delivered by other county health departments or organizations, and nurse practitioners have attended training on sports injuries or diagnosing mental illness. Two or three times a month, all clinic staff meet for several hours to address organizational issues identified by the county or ones they have mutually chosen. They may discuss ways to implement consensus decisionmaking or evaluate quality improvement activities to see how effectively staff are providing family planning or monitoring immunizations. Recently, staff at one school-based health center decided to conduct a survey so students could grade the clinic's health education and services.

Although professional development activities should target the concerns of both health professionals and educators, professional development on health issues is typically far more limited for educators and school staff—even though sources agreed that teachers are better prepared to participate in and contribute to health linkages if they understand medical issues, treatments, and roles. In the sample used for this book, most professional development for educators occurred very informally when clinic staff sought opportunities—at school events, faculty meetings, assemblies, or during lunch periods—to build relationships with school staff, answer questions, and build understanding about specific issues (e.g., the use of Ritalin). Given the challenge for both health and education professionals in understanding each other's language and practices, mutual professional development

opportunities would benefit collaborators on both sides of the linkage.

Establishing an Organizational and Management Structure: Key Roles and Oversight Groups

The structure and composition of a management group often looks different from that of a planning group. At the very least, the roles of participants are likely to change from building support and designing a program to maintaining support and handling ongoing management. Establishing a productive group means defining roles for key collaborators—including staff as well as entities such as school districts—and striking a balance between on-site autonomy and accountability to the collaborating institutions.

Informal Organizational Structures

Most sites relied on close-knit but informal organizational structures that combined hands-on, site-based management with regular oversight. This gave the programs autonomy while maintaining coordination between the schools and health providers.

Most sources say the informal structure helps give a program breathing room, but the reliance on *ad hoc* communication has its drawbacks; one district administrator noted that it would be easier to build support for the effort if there was a mechanism to keep top administrators more informed about the program.

The sites in our small sample generally did not make formal connections with broader education reforms, although principals and teachers noted that the goals of many education programs and of health linkages—addressing the needs of high-poverty, disadvantaged children in order to improve their ability to learn—often are the same. A possible exception is the Bridges to Success (BTS) program in Indianapolis which, as explained elsewhere, is part of a broader effort to integrate education and human service delivery to serve at-risk children and families. At this site, each school involved in the collaboration has a site team composed of parents, teachers, school administrators, health and social workers, community members, and students. The team provides a mechanism for linking health and education reforms by identifying academic, medical, and other needs and providing guidance in addressing them.

Informal organizational relationships between school-health linkages and school districts often reflect deep-seated views on the proper role of education and health providers that can have an extensive and lasting impact on school health programs. For example:

An Informal Organizational Structure

The urban, school-based program operated by Southeast Lancaster Health Services in Lancaster, Pennsylvania, illustrates a typical arrangement that involves school district staff (the coordinators of pupil services and health services and the business director), principals, school nurses, the health center's medical director, the clinic physician, and physician assistants. The medical director oversees the program at schools and supervises the physician and physician assistant, while the center's executive director handles billing, contract negotiations, and longterm decision making. Although the school district reviews accountability data, the relationship between the school-health linkage and the school district is mostly informal. Periodically, the school district convenes a meeting of all people interested in school health care to discuss relevant issues. A recent meeting focused on the county's decision to shift to mandatory managed care and how it will affect services for students whose primary care physicians are not at the school-based clinic. Other meetings have addressed enrollment or billing issues.

The informal structure at Lancaster builds on relationships among key players that predate the school-health linkage. The health center's executive director had worked extensively with the assistant superintendent of schools on other projects and is a friend of the grant director; the assistant superintendent of schools grew up in the area and understands the need for school-health linkages; and the health center's head nurse—a 20-year veteran—had worked with every school nurse in town and was respected for her administrative and clinical skills.

At Clinica Adelante in Queen Creek, Arizona, the school-based clinic and the school district are financed entirely separately and have separate governing boards. The school board does not have authority over clinic activities, although it can establish guidelines for health education and services provided directly on school grounds. Board members and administrators of Clinica Adelante have not made any formal arrangements with the school district other than to lease the clinic's office space. Lacking formal organizational ties, the school-health linkages function primarily because of individual relationships and a shared commitment among school and clinic staff to the healthy development and learning readiness of children.

This institutional separation is based on a strong community belief that schools should provide only education, and health and welfare agencies should provide social and health services. Residents and parents are particularly concerned that schools avoid issues related to sexuality. This view extends to the activities and policies of the school board and town council; as a result, an AIDS education program was implemented in Queen Creek only because it was mandated by the state, and it was tightly scripted by the school board.

Formal Organizational Structures

A rural program based at a family center in Florida uses a coordinator, hired by the school district, to oversee and coordinate the relationship between the school and the service agencies based at the family center. The coordinator interacts regularly with the school's principal, guidance counselor, and faculty to help them understand the services available and identify children in need of services. The coordinator also helps service providers coordinate efforts across agencies and make referrals to outside agencies. Issues beyond day-to-day coordination and management at this site are addressed jointly by the school board, officials of the contracted service provider, center staff, school administrators, and the site coordinator. An oversight committee meets quarterly to direct future growth and development and to make budget recommendations. Committee members include principals; school board members; business leaders; and representatives of several social service agencies, the community college, and the public health unit.

Similarly, at a high school in Portland that has one of the county's seven school-based health clinics,[13] the clinic coordinator meets every other week with a designated school liaison (a vice principal) and always consults with the principal before interacting with outside agencies.

Formal Organizational Structures

More formal structures are useful when programs grow larger and more comprehensive. The fact remains, however, that school-health programs are hybrids, and each contributor wants a say in the program's design and management. Programs that try to link many contributors may be able to provide an enviable smorgasbord of services, but they may also struggle with coordinating oversight of these services. Even with formal organizational structures, it isn't easy to coordinate management between the separate entities involved in a school-health linkage—or even *within* each of these entities.

Even Formal Organizational Structures Can't Eliminate All Institutional Barriers to Coordinating Services

The Logan Heights Family Health Center, which operates a school-based clinic at an alternative school for homeless youth in San Diego, initially had trouble coordinating the many levels of its own bureaucracy to manage the school-health linkage. The health center's first attempt—a walk-in teen clinic that predated the school project by one year—involved staff from the center's departments of health promotion, pediatrics, and women's clinics. The staffs did not always agree on billing practices, the relative importance of services, and whether the program should focus on sex-related services. Confidentiality protocols also posed a problem, because staff from the pediatric division had less-stringent rules than staff with adult HIV/AIDS experience. When the health center expanded its efforts to the school, even more internal departments became involved.

At another urban, school-based site, medical and mental health staff are frustrated because they feel supervisors at their off-site corporate headquarters place unfair pressures on the school-based staff and do not understand the issues they face. Although the frontline medical workers have more autonomy than some of their peers in corporate environments, they say it is autonomy by default: "Out of sight, out of mind." At the same time, practitioners say they are pressured by off-site supervisors who want to increase productivity but don't understand that high-need patients require more time or that the school-based clinic has less support and fewer facilities than the main clinic.

Organizational Groups in Rural Communities

In rural communities, where collaborators tend to know each other well and sometimes serve several roles in the community, organizational links between schools and health centers may be especially close. In Konawa, Oklahoma, for example—a community of 1,600 residents—

[13] Multnomah County was in the process of opening three additional school-based health centers at the middle-school and elementary levels at the time of our site visit.

collaborators say that the overlap among leaders helps build a sense that everyone is working toward the same goal. Two school board members and four teachers sit on the health center's board of directors, and the vice president of the health center board is also the director of community education for the town's only school. Six school administrators sit on health center policy boards; school and clinic staff attend each other's board meetings; and the health center's family nurse practitioner is also the "physician" for the school's football team, creating strong ties with students.

Providing Oversight Through Advisory Committees

Advisory committees, which often emerge during the early stages of program planning, also play an important role for most school-health linkages, especially during the design and planning stages, by providing a structure for problem solving and averting turf barriers.

These committees can be informal groups of community members or collaborators involved in other aspects of education or service provision. For example, Southeast Lancaster's school linkage does not have an advisory committee—but King Elementary School, which has one of Lancaster's school-based service centers, has a coordinating council for its family center to which clinic staff belong. This committee meets weekly to coordinate services among the school, clinic, and family center for students with special needs.

Advisory committees offer useful strategies for changing the design of school-health linkages. At a high school in Portland, for example, the vice principal in charge of curriculum serves on the school clinic's advisory board. Recently, the school's health teacher (who is not part of the clinic but sits on the advisory board) raised the issue that the school does not provide health education until the sophomore year, yet many health-risk behaviors begin during freshman year. Clinic staff already were concerned about this gap; together, the health workers used the vice principal's participation on the advisory board as an opportunity to raise the issue and ask for a curriculum change.

Advisory committees also provide a natural forum for attracting and mobilizing collaborators, as the planning activities of a broad-based committee at one urban site illustrate: Members identified principals who were willing to accept a clinic, located agencies that were interested in providing services, collected information on similar programs from other health centers in the state, consulted with state education officials, and visited other sites in the state. As planning progressed, the committee broke into smaller groups to address such issues as staffing, equipment, hours and protocols for operations, facility design, and budgets. The planning committee eventually became a permanent consortium of all entities interested in integrating services—a useful trouble-shooting mechanism for the school clinics. Now, a principal says, "When we run into a barrier, we kick it up to the consortium and tell them to get rid of it."

How One Advisory Committee Provides Oversight

Each of the school-based clinics in Multnomah County (Oregon) is required to have an advisory board composed of parents, teachers, students, and community members. Most of Portland's advisory groups have about 10 members and meet quarterly, although when the program began the groups met monthly. At first, participants had trouble understanding whether the board should take an advisory or a governing role; because planners lacked experience in developing such groups, it took time to sort this out. But the board proved useful in building support for the school-health linkage. "The board is important because they will advocate for you and let you know if [the clinic has] bad images in the community," one planner says. In addition, a pediatrician who initially thought he would lose business when the school clinic opened realized through his membership on the board that he would actually receive referrals for services the clinics didn't provide—and that the clinics would take responsibility for school-age patients who couldn't afford a private pediatrician. Because organizers found that most groups work best when they have something to respond to, program leaders now use the board to gain feedback on draft policies and procedures, to offer advice on the best way to reach parents and community members, and to solve problems as they arise.

Parental Consent

Parental consent systems varied among sites, but most sources agreed that consent can be helpful or even crucial to a school-health program's success in treating students. One-third of the sites in the sample require a signed parental consent form that grants permission, either annually or permanently, for a child to receive school-linked health services. More than one-third of the programs require limited parental consent (e.g., for mental health care only or for children below a certain age). Two sites require parents to be present when their children receive services.

A program's choice of a consent system is influenced by state law, school district mandates, or a desire to improve program operations and patient participation. A program's experience with parental consent also is influenced by the extent to which parents were involved in program planning.

Requiring Parental Presence

Programs that require parents to be present when their children receive services usually do so because it allows clinic staff to communicate directly with parents or increases the clinic's opportunity to obtain reimbursement for services. Fort Pierce's Family Service Center, for example, requires parents to accompany their children to the clinic in the hope that parents may be able to pay for some or all of the services; the health center, although a non-profit organization, is not a public health unit and must cover its costs. Sites that use this system must have a back-up strategy for cases in which the parent cannot or will not come to the clinic; some sites arranged to have principals grant emergency permission in these instances.

Requiring Signed Consent

Typically, programs that require signed parental permission distribute consent or "enrollment" forms to parents at the beginning of the school year or during registration. These forms are kept at the school-based clinic or health center and often contain a brief medical history as well as permission for treatment. In at least one site, the form also identifies the child's primary provider and preferred pharmacy. The schools that participate in the health linkage usually have responsibility for distributing the forms, although responsibility for collecting them lies with the health staff: If a student arrives at the clinic and does not have a card on file, clinic staff call the parents and arrange for permission. (Most sites said that in these cases they provide health care on a one-time basis but inform parents that they must file the form in order for the child to receive care again.)

Programs that require parental consent sometimes make limited exceptions for students who have chronic illnesses that require attention, such as asthma or diabetes. They may also make exceptions for emergency situations, in which a principal usually is allowed to authorize services, or for certain services that are exempted by state or local law, discussed in more detail below. Rules that govern different types of services may vary on parental consent requirements, however, putting clinic staff in the uncomfortable position of choosing one policy over another. In Portland, for example, children who are at least 15 years old can receive health services without parental consent—but the mental health department's protocols require parental consent for psychotropic or antidepressant drugs, even for children who can legally consent to health services. School-based clinics at this site chose to follow the more restrictive mental health policy.

Although two sites allowed parents to grant permission for services for as long as their children are enrolled at the school, most sites require parents to sign a new consent form every year. This presented problems for at least one site, Southeast Lancaster, which saw dramatic changes in its consent rates—a dropoff of 200 "enrollments" in one year—despite increased

parental satisfaction with the program. Staff say they have had trouble getting parents to understand that consent must be renewed every year. This has had a significant impact on the program, because the consent form also allows the clinic to collect reimbursement from insurers. To increase parent awareness, clinic staff attend parent conferences and PTA meetings, and the school nurse talks to parents about the clinic and sends materials home with students.

Limited Consent

Programs that require consent for some but not all services usually are responding to state or local laws designed to increase children's or adolescents' access to health care. These laws, which may carry age limits, usually govern mental health care, family planning, or the diagnosis and treatment of sexually transmitted diseases. For example:

- Valley Wide's school-based program operates under a Colorado law that does not require parental consent for health services except for mental health care for children under age 15.

- Portland's school-based clinics are governed by an Oregon law that allows students of any age to receive family planning services without consent and allows youths above age 15 to receive STD or mental health care without parental consent; other patients under age 14 must have a signed consent card.

- Students who use Konawa's school-linked mobile van do not need parental consent for reproductive services if they declare themselves sexually active and manage their own birth control—although all other services require consent.

Even for services that do not require parental consent, however, school-linked medical staff say they often encourage parents or guardians to be present during an examination so they can follow the exam immediately with a parent conference, reducing the potential for misunderstanding and improving the chance that parents will follow up on additional treatment. Parent involvement is not always possible for adolescent students, who may be estranged from their families.

Coordinating Referrals and Appointment Schedules

Referrals establish the critical links between students and needed health services. Arrangements for referrals—from teachers, parents, and students to the school-health program and from the program to other health services—determine the extent to which the program improves students' access to service.

Referrals to the School-Based or School-Linked Health Program

All of the sites in the sample accept referrals from students, parents, teachers, or school administrators. Although programs do not always keep statistics on referrals, self-referrals and referrals from school nurses, teachers or principals seemed to be most common.

Designating a gatekeeper for referrals. Most sites streamline the referral process by designating one staff person—often a school nurse—to receive referrals, assess priorities among students requesting services, and refer cases to the nurse, physician, or physician assistant on duty at the school or community health center. At school-based sites, this gatekeeper usually also measures the student's height, weight, blood pressure, and temperature; gathers a brief history of the illness; and may contact the referring teacher or parent for more information. At school-linked sites, the gatekeeper keeps communication clear between the school and the health center by collecting referrals from teachers and conveying them to the clinic staff in an organized way.

Designating the school nurse as the referral contact can smooth implementation in several ways. First, these nurses usually know individual students and teachers best; the nurses can use their knowledge of clients' use of health services when assessing students' medical priorities. Second, teachers and administrators recognize school nurses as part of the school and are likely to approach them with concerns. Third, school nurses often are restricted by school rules from administering more than basic health services, but assessing medical priorities among students gives them a valuable role, integrates them into the school-health linkage, and frees clinic staff to perform other services.

Centralized referral systems can limit teachers' direct involvement with clinic staff and reduce opportunities for coordination, however. At one rural site, the school's 28 teachers make referrals to the school counselor or the principal's secretary, who schedules clinic appointments. There is no formal process for letting teachers speak directly with clinic staff. In this case, health center staff rely heavily on the community's small-town atmosphere to promote informal communication between teachers and clinic staff that will keep both sides informed.

Encouraging self-referrals by students. Clinic staff were unanimous in their advice for building support among students and attracting them to the school-health programs: (1) Treat them with respect, (2) don't judge their behavior, (3) cultivate word-of-mouth referrals from students you've successfully treated, and (3) spread the word by visiting places or events where you may find potential patients, such as classrooms and summer sports camps. "I think [providers] tend to have a tendency to 'save' people—and first you just have to take care of the basics," said one nurse, explaining why school-health services should be judgement-free. "People need to feel safe." Clinic staff frequently conduct classroom presentations to try to attract students to school-based or school-linked health services. Typical topics include sexually transmitted diseases, sex education, and basic health care.

School-health programs seem to have greater success attracting girls than boys. Several sites try to attract male students by offering sports physicals, with some success. One school-based clinic's entire medical team accompanies the school's football coach each spring when he visits middle schools; the health staff distribute pamphlets describing their services and ask students to sign up for physicals. In June, clinic staff call these students to set up appointments for the beginning of the school year. (To accommodate the increased demand for services during this time, the clinic opens a few weeks before the school year begins and remains open a few weeks after school ends.)

Generating community-based referrals. Programs that focus on attracting community—rather than school—clients follow different procedures to cultivate referrals. At the school-based Fort Pierce Family Service Center, for example, only a small percentage of clinic users are referred directly by the elementary school, although many are referred by other schools in the district. Most users are not even of school age; they are identified through community outreach and referrals from other social service agencies. Outreach at this site includes inviting community groups and service agencies to tour the family center, offering staff as speakers for community groups, disseminating a district-wide newsletter, inserting articles into school newsletters, sending flyers home with students, and promoting services on the district's cable television channel.

Scheduling Appointments with School-Based Providers

Arrangements for scheduling student visits to the school-linked or school-based program must balance students' needs for health care with

their class schedules. This is a critical aspect of coordination between school and health staff—the process should ensure that students are accounted for and that they do not consistently miss a particular class to visit the health program. Common arrangements include requiring that they have a hall pass, as in the case described earlier, and requiring students to sign in when they arrive at the health center. Students also must typically sign out when they leave and obtain a hall pass from a health provider for the trip back to class.

If students require regular visits to health providers on site (e.g., for counseling groups, allergy shots, monitoring of a chronic condition), health staff try to make the appointments during lunch or after school. If this is not possible, they may also rotate appointments so the student misses a different class each week. Clinics also try to reschedule appointments if they interfere with tests or other important classroom activities. Valley Wide clinic staff try to see each student at least once during the academic year, and teachers sometimes complain that students miss class time. The clinic has tried to address the problem by scheduling clinic visits during various times of day; teachers can ask students to reschedule appointments if they feel that the student should not miss the material being covered in class.

Referrals to Outside Providers

All programs refer acutely ill students to the community health center's main clinic or to a local hospital. Students who require comprehensive health services not offered by school-based programs are referred to the community health center, other agencies or practitioners, or primary care providers. For example, students in Valley Wide Health Services' rural program who need drug abuse treatment or mental health care are referred to the county mental health center; a Valley Wide representative often accompanies students on their first visit to the mental health center.

Coordination with other providers. Referral relationships with students' private physicians—for students who have private physicians, a minority—vary in terms of cooperation but seem to benefit most from direct communication between the school clinic staff and private provider. In Southeast Lancaster, for example, when clinic staff need to coordinate services with a family physician the clinic physician calls the family doctor directly and asks permission to observe the child and to confer with the family doctor. Some family doctors have responded by giving the clinic physician permission to treat students. In fact, sources report that most providers outside the program are cooperative—except when the student is uninsured or, in some cases, the student is a Medicaid client in a managed care system. In this case, school-linked health providers have to work out arrangements with individual managed-care providers, some of whom prefer that students maintain a single medical "home" within their network. A discussion of arrangements for serving and obtaining reimbursement for students enrolled in managed care networks is contained in a later section on funding and reimbursement.

Even when students lack health insurance—and sources estimate that between 25 percent and 75 percent or more of their clients fall into this category—most programs in the sample have identified clinics or private practices that will accept a limited number of uninsured patients. In these cases, the patient may need to wait for an opening or for a clinic staff member to help the family register for Medicaid. Sources report few effective strategies for pressuring specialists to take uninsured patients, other than repeated "pushing and begging." Outside referrals can be complicated by the fact that many communities served by school-health linkages simply do not have alternative sources of care.

As with referrals to a school-based or school-linked program, programs find it most efficient to designate one staff person to handle referrals to outside providers; this is usually the physician, lead nurse, or site coordinator. At rural sites, where the same people often serve on the governing boards of mental health or social service organizations, juvenile justice institutions, community groups, and sometimes schools, it's easy for care providers to contact one another and for the school-based clinic to make referrals to other organizations.

Efforts to Coordinate Referrals *from* a School-health Program to Other Community Services Also Generate Referrals *to* the School-linked Program

A principal with a school health linkage in the Valley Wide program, for example, recently joined other health service providers in a coalition to design ways to integrate health care referrals without violating patients' confidentiality. Representatives of the valley's six counties belong to the group, including mental health and social services departments; the group hopes to establish and improve linkages between programs and with schools so the referral system will work faster.

Three programs that have relationships with other providers built into their design—San Diego's program linked to an alternative school for homeless youth, Portland's school-based health centers operated by the county health department, and Indianapolis' program at School 50, which links with other providers through Bridges to Success—find that these relationships facilitate referrals to outside providers. As one coordinator explained, a teenage client is more likely to follow up on a referral—and get an appointment more quickly—if clinic staff can say to the student, "Go see so-and-so at such-and-such agency and tell her I sent you."

None of the sites in the sample gather statistics on the types of services for which outside referrals are made. Several estimated referrals by type of service; these ranged from one site that refers about 10 percent of students for outside services (mostly for ear/nose/throat problems, behavioral or family counseling, surgery, or acute emergency care), to one that refers 50 percent of students for dental needs and 60 percent for hearing problems.

Importance and difficulty of follow-up to referrals. All sites that make outside referrals conduct some sort of follow-up to see whether students actually receive services, usually by having the clinic nurse call the student's parent or the service to which the referral was made—but sources say a lack of money or transportation often keeps students from following up on the referrals. Some sites provide transportation for students and their families, but rarely on a regular basis. Staff at Clinica Adelante drive patients to providers in other communities, but the distances are so great that such trips are too time-consuming for staff to make often.

Follow-up services for referrals also are difficult to provide because students don't keep appointments and because the disadvantaged population targeted by these programs is often very transient. One urban site that has a part-time transportation service tries to improve follow-up by making referral appointments for days on which the van service operates; the program coordinator supplements this by calling patients to remind them of their appointments a day in advance. Still, the coordinator finds that many students fail three or four times before keeping an appointment.

Addressing Confidentiality Issues

Educators and health care providers are governed by strict confidentiality and privacy laws that prevent them from readily sharing information about students. Yet school-health linkages consistently face demands for information sharing among school and health staff trying to help individual children. Confidentiality is important not only to protect the privacy of students, patients, and families, but also to establish trust between health professionals and the patients they are trying to serve. Client perceptions of confidentiality are as important as legal enforcement; if a student fears that a nurse practitioner who visits the school once a week will tell any teacher who asks whether the student is

pregnant, she isn't likely to visit the center for care. At the same time, each of the concerned adults involved with a child wants—and may also have a legal right—to know what's happening with the child. Sites cope with these competing demands by developing strategies for sharing information with parents, teachers, and other human service agencies. Part of this approach entails formal procedures, but it also requires that school-linked and school-based service providers spend time building trust among parents and students in their qualifications and discretion.

Confidentiality and Parents

Medical sources at all sites gave primary importance to confidentiality between patients and health care providers, especially regarding reproductive services. This is consistent with normal medical protocols and also is crucial to convincing students (especially adolescents) to use health services. At the same time, parents want access to information on their children's health. Several sites in the sample that are linked to elementary schools addressed this issue by requiring parents to accompany their children when they receive services. Other sites insisted on maintaining confidentiality even to the detriment of relationships with parents. This is especially true for services to adolescents, who may be estranged from their families.

The confidentiality issue is most problematic in school-based clinics, where students receive services within the school and parents therefore feel they are entitled to information, just as they would be from a classroom teacher. All school-based clinic staff said they respond by encouraging parents to visit the clinic. They believe that such visits reassure parents that their children are receiving appropriate care from qualified providers, even if the medical staff is not allowed to describe the nature of the care. All medical staff also said they strongly and repeatedly encourage students to discuss their medical needs with their parents. One nurse practitioner described role-playing to help one of her patients decide how to tell her parents she was pregnant.

Billing for reimbursement from Medicaid and private insurers can also create confidentiality problems with parents, because these organizations may send statements with confidential information to the patient's home. Clinic staff usually make a point of warning students about this predicament and, in at least one site that serves adolescents, will not bill for reimbursement if it would jeopardize the student's confidentiality.

Clinics may be required by law to keep certain health matters confidential, regardless of age. At Indianapolis' school-based program operated by HealthNet, for example, state law says that parents do not have to be notified if their child has a sexually transmitted disease or is pregnant. The law in Colorado is even stronger: Clinic staff in Valley Wide Health Service's school-based program are required not to tell parents if their child has a sexually transmitted disease.

Confidentiality Between Health Care Providers and Teachers

Confidentiality issues can and do create tension between teachers and clinic staff. Many referrals to clinics come from teachers, who know that their students are having problems and want to be informed—especially when depression may be involved. But clinic staff, operating under standard protocols and professional ethics for patient-physician relationships, feel compelled to keep information private. (The obvious exceptions are cases of child abuse or neglect.) "If we have erred at all, it's been on the side of confidentiality for the kids," said one principal.

The logistical needs of the multiple collaborators that are often involved in school-health linkages—schools, health centers, and social service agencies or organizations—also present potential confidentiality problems during implementation. School-health programs must work out who "owns" a student's health records and

which confidentiality rules—those designed by the school or those used by the health providers—should be followed. For example, schools at one site keep "health folders" on every student; by law, these files are open to parents and teachers. When school-based clinics first opened in this community, schools assumed that health information from the clinics would go into these folders and were miffed when the clinics refused. At one clinic, school administrators began dropping by to ask which students had been seen, and for what medical reasons. "You tell me who in here has AIDS and I'll have them thrown out of school!" one principal allegedly shouted at clinic staff. At another site, sources reported that although they follow standard medical protocols for patient confidentiality, they are also instructed not to counteract school policies, which include informing parents of a child's life-threatening conditions.

To resolve these barriers, medical and other staff that work with schools must communicate with school staff about the confidentiality rules that govern their agencies. Staff need to be clear about where their procedures differ, why, and how to handle conflicts when they arise. In one case, the health care provider that operated the clinic gave clinic staff orientation on ways to politely resist giving out information. According to sites, the key to reducing tension lies in understanding up front that confidentiality will be an issue, and making it part of early and continuing negotiations and training between school and health planners.

Confidentiality and Other Service Agencies

The communication required for collaboration among several agencies or organizations that provide services for the school-health linkage also raises confidentiality issues. Each service provider wants to know what services their clients are receiving from other providers. The Fort Pierce Family Service Center experienced this regularly, and its solution was to develop an interagency consent form, modeled after a standard medical consent form. The consent form is a common solution to confidentiality issues among school-linked services providers. Families must sign the form before students can receive services or exchange information with other providers. The form allows clinic staff to share information with staff from the collaborating agencies. With permission granted by this form, members of the medical, mental health, and school staffs at this site can meet weekly to discuss patients and members of the mental health and medical staff regularly participate in teacher-parent conferences. The only complaint about these forms among staff was that they do not contain an expiration date, a feature that mental health staff feel is important for protecting their clients.

Rural sites in the sample found that confidentiality and privacy can be especially hard to maintain in a small-town setting. At these sites, clinic staff often remove information about reproductive services from a student's medical chart if he or she visits the clinic with a parent or guardian for another medical reason. This strategy isn't always sufficient; staff from a mobile van at one site thought this solution would encourage students to flock to the school-linked program for reproductive services, but because the van is highly visible in the small towns, students are still reluctant to use it for information on sexual matters. Instead, the nurse suggests that these students visit the mobile van when it stops in a neighboring town.

Finally, although most school-health programs can't afford sophisticated computer systems, it's worth noting that the same technology that facilitates coordination among services providers may also threaten patient confidentiality. Medical staff at a site that is developing a computer network for sharing patient information among schools and service agencies, for example, are pleased that the

system will reduce the paperwork burden and lag time and will improve program evaluation by providing access to school data. But they are also uncomfortable with the potential for misuse or unauthorized access and are trying to find mechanisms to prevent this.[14]

Developing Procedures for Self-Assessment and Evaluation

Community and migrant health centers and schools share an interest in improving the health status of children and families in their communities—especially when it comes to addressing the health problems that interfere with learning. Whether school-linked and school-based health services have an impact on these problems depends on the quality of services provided, and the extent to which students use the services.

It is critical that school-linked and school-based programs document their successes and learn from their failures. Procedures for self-assessment and evaluation are difficult to think about in the midst of planning and developing a program, but early attention to these issues can help build credibility, flexibility, and sustainability over the long term. Although the traditional purpose of evaluation is to document the outcomes of services and activities, collecting ongoing process information helps facilitate self-assessment and program improvement. The outcomes are still important—but what a program does in response to poor outcomes is just as important, if not more so.

All sites in the sample have basic procedures for ongoing self-assessment of health services. Fewer sites document patterns of service utilization, although most gather basic information to fulfill funders' reporting requirements. This information usually focuses on documenting the processes involved in providing services, and access to services, rather than on the outcomes for students. Two sites are implementing formal evaluations to assess the impact of their school-linked programs. These programs hope to demonstrate that school-linked or school-based services improve health and educational outcomes as well as access for students who use them. Other sites indicated regret that they had not been able to fund evaluations, since information about the benefits of their programs would help them in their quest for continued and expanded funding.

Anecdotal Evidence of Success

In most cases in our sample, programs measure progress anecdotally. Because a major goal for these programs is access to services, staff view increases in the number of students coming for services as an indication of success. "Just walking around the school is all you need to assess the program—the amount of students who know who we are, the amount of parents who send notes wanting [children] to be seen, the trust level," said one health care provider. School staff frequently credit school-based services with keeping students in school—although the links to increased attendance again are usually established anecdotally rather than formally:

- School staff at King Elementary School in Lancaster say that their school-based clinic has enabled students with infectious diseases to avoid missing school by obtaining immediate treatment on site. Without the clinic, state rules would require these students to stay out of school until they begin medical treatment. King's average daily attendance rate is 95 percent, and the principal attributes at least 2 percent to the existence of the

[14] For further discussion of the relationship between information systmes and comprehensive services, see Information systems to support comprehensive human services delivery: Emerging approaches, issues, and opportunities by C. Marzke, D. Both, and J. Focht (1995), published by the National Center for Service Integration in Des Moines, Iowa. To order this and other resources published by the National Center for Service Integration (formerly located in Falls Church, VA), call (515) 280-9027 or write: NCSI, 218 Sixth Avenue, Suite 1021, Des Moines IA, 50309-4006.

school clinic. "Before we had a health clinic, we would maybe have a home visitor or teacher talk to the parent about a child's [problem], and many times the parent neglected to follow up," the principal explains. "This way, follow-up is done immediately and the child doesn't lose any time. The longevity of the absence is reduced—instead of four of five days out, they lose only one day."

- Attendance at Jefferson High School in Portland has improved since the clinic began providing services, from about 60 percent to between 75 and 80 percent. In several cases, the school has avoided suspending or expelling troubled students by enabling them to obtain mental health services at the clinic while they continue to attend school. The principal credits the health linkage with improving the dropout rate and encouraging former students to re-enroll, but no data are available to support this.

- When the clinic at Sierra Grande opened, the school's attendance rate was in the 70 percent range; in 1992-93, it was 94 percent. The principal attributes at least 10 percent of this change to the health services provided by the clinic, including nutrition and pregnancy counseling. Since the school-based clinic opened, the teen pregnancy rate at Sierra Grande has declined from 8 percent to zero, the lowest in Colorado. Administrators have not seen such dramatic changes in school performance, but they note an improvement in students' general attitude simply because students know there are adults available who have answers and will share them without judging. Teachers' attitudes also have improved as they see more children staying in school instead of getting pregnant and dropping out.

Self-Assessment

Self-assessment efforts must be regular and ongoing to be effective. Programs should analyze measurable aspects of quality, and the results should lead to changes that augment quality. Although books and other resources can guide planning and development, the implementation of a school-linked health program is rarely a simple, direct process; no program can anticipate exactly how it will operate once in place. Programs therefore must monitor the extent to which services reach the students they target and the extent to which they match these students' needs. In addition, most programs that use public funds must assemble data on the number of students served, types of services, and expenditures for reporting purposes.

Most sites also try to track certain information so they can make informed decisions about ongoing changes and adjustments. At a minimum, many sites track:

- The number of students who use the health services
- What services are provided
- Student, parent, and community satisfaction with services

These data often are part of a student's patient record and are extracted and summarized periodically for review and assessment.

Manual collection and assembly of data and reports are time-consuming. Because of limited staff time, collecting data manually is "just about an impossibility," said a physician at a site that tracks the number of visits made to the clinic each year but does not gather data on diagnoses or treatment. Clinic staff expect a new computer system to facilitate more sophisticated data collection, identify diagnosis trends and patterns of use, and add more self-assessment mechanisms. In this respect, programs affiliated with large, established infrastructures like a county health department have an

advantage in data collection because these organizations usually have a system in place for collecting and analyzing information. In Portland, for example, the health department's director of school-based clinics receives a monthly productivity report that includes statistics on the number of clients and visits to each clinic per month, quarter, and year; the type and number of services provided; and the number of patient contacts made by each staff member per day.

Several sites also conduct surveys and focus groups to determine whether people are aware of the services, whether they use the services and why, and what degree of support exists for certain services. The health center located near Fort Pierce Elementary School conducts surveys of students, parents, and school staff to gauge client satisfaction and assess the extent to which the program fills the gap between unmet needs and services. Feedback shows that the centers' users are the highest risk categories of students; their presence in the clinic confirms that the targeted clients are using the center and finding its services acceptable. Over time, clinic staff hope the records also will show a reduction in their clients' risk behaviors. Similarly, clinic staff in Lancaster initiated a roundtable discussion with parents to elicit feedback, and Valley Wide surveys students twice a year to identify why they use the clinic and to evaluate service quality. These programs report survey data to funding sources and use them for program planning.

In addition to gathering data about the program, sites have developed procedures for monitoring and improving service quality. Because school-linked and school-based health services often are provided by nurse practitioners operating away from their medical "homes," they do not always have direct access to the physician responsible for supervising staff. Typically, the participating community or migrant health center establishes protocols for nurse practitioners or physician assistants to follow during examination, diagnosis, and treatment. These remain in effect even if the practitioner works at a school or in a mobile health van. School-health programs also ensure that front-line health staff have access to a physician for assistance and back-up. Most school-based clinics bring physicians on site regularly to review charts and see patients.

Formal Mechanisms for Gathering Information

Valley Wide's director of adolescent health monitors the program by reviewing a monthly, computerized update of daily services that indicates the number of students served.

Bridges to Success in Indianapolis hired an independent consultant to evaluate the program's processes and outcomes. The consultant released two papers in early 1994 that summarize the program's key concepts and strategies and an interim evaluation in late 1994. The evaluator's data came from on-site interviews, focus groups with parents and community members, and reports from on-site coordinators; evaluation topics included services provided, strategies used, implementation issues, and barriers.

In Fort Pierce, the community health center (FCHC) tracked eight program goals and objectives for the 1993-1994 school year. For example, one stated that "FCHC would provide well-child screenings and immunizations to 1,200 children per year per provider at [two] elementary schools." The program reported achieving 64 percent of this goal. Another goal was to "provide early screening, diagnosis, and referral for treatment of lead poisoning in...county children." Another goal focused on providing outreach to community groups; actual achievement of this goal was reported as 100 percent. This program also measures compliance with appointments; before the center opened, less than 53 percent of patients showed up for recommended services, but compliance is now about 90 percent.

In Portland, school-based clinics keep a written "encounter record" of every visit made to every center, coded by diagnosis and including demographic data. The findings are included in the program's annual report and provide baseline information on why students use the centers to help with program planning and needs assessment. For example, after the clinics' first year, the visit records showed a strong need for mental health counseling, so a part-time counselor was added to the clinics' staff; when records of waiting lists and student demand showed a growing need for these services, the mental health staff became full-time. The data also allow the clinics to plot changes in student-staff ratios, anticipate needs for future sites, and respond in detail to questions from the public regarding students' use of the clinics.

Examples of Ongoing Self-Assessment

In Multnomah County, Oregon, the county health department has infused the school-based health clinics with a philosophy of continuous quality improvement. Because the clinics are autonomous, staff receive training in self-directed work team techniques so they can develop their own team priorities and ground rules. The county has provided program policy guidelines that every site will use to maintain consistency. According to one clinic director, new clinic staff tend to view continuous quality improvement activities as separate from their job and think that they won't have time to perform chart audits and other monitoring tasks. As they spend more time at the clinics and come to view parents, students, and school staff as clinic customers, however, staff are more likely to integrate these activities. The key lies in periodic reinforcement, orientation, and high expectations for job performance, the program manager says: "In a sense, we're evaluating [informally] all the time and making little adjustments."

Self-assessment at Valley Wide's health center involves reviews of staff credentials; chart audits to check compliance with protocols; staff discussions of procedures and examination of equipment to address safety issues; and a patient satisfaction survey. The doctor is in regular contact with the nurse practitioner or physician assistant, and supervisors conduct annual reviews of clinic staff.

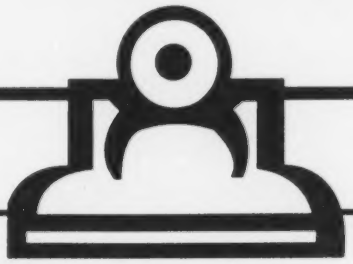
Documenting Impacts: Getting Beyond Anecdotal Evidence of Success

Few school-linked or school-based programs are conducting evaluations to determine the impact of their services on students' health status or educational achievement. In fact, there is little statistical evidence in the literature about the health or educational effects of these programs. In part, this is because designing solid, rigorous evaluations for school-linked services is very difficult and can be expensive. Data collection also uses limited staff time. Clinic staff would prefer to evaluate their programs by conducting in-depth studies that follow clients over time, but this requires more case management and interview time than is usually available.

In addition to resource constraints, there is a certain risk inherent in evaluation. For example, program leaders at several sites are frustrated because as they begin to treat more people and collect more data on health problems, disease rates appear to climb because more cases are identified. This is the case in San Diego regarding tuberculosis rates and in Portland regarding teen pregnancy. This sort of risk can be mitigated if the evaluation is treated as a tool for internal learning and program improvement, as well as for research and accountability. A good evaluation explores the reasons that a program succeeds or fails to attain expected impacts, and helps point to ways to correct the problem. Despite the cost and risks, program staff and leaders recognize that evaluations are extremely important for program redesign, expansion, and funding.

Two sites in the sample are designing evaluations in hopes of obtaining hard data on the effects of their school-based programs. In 1994, the school-based program in Portland began an evaluation that will include a telephone survey of parents, a student survey, and a survey of school personnel using instruments designed by a professional researcher. Program leaders hope to repeat the evaluation every two years but are concerned that schools are already overburdened by surveys.

Also in 1994, the school district in Fort Pierce formally asked all agencies providing services through the health center to develop measurable, outcome-based treatment plans. The county school district is developing a computer network that will eventually allow the school system and service agencies to share information on students. The primary goals of this system are to provide electronic networking capabilities that will reduce the burden of paperwork and information transfer on families who interact with several agencies, and to aid in program evaluation by linking school data with services provided. The major barriers to this project are confidentiality and security; people are uncomfortable with the potential for misuse or unauthorized access. Planners intend to begin collecting



Additional Tips from the Field

- To demonstrate a school-health program's success in meeting the needs of at-risk students, collect school data as well as health information. Compare attendance rates and other school-oriented indicators between schools that have health linkages and comparable schools in the same district that do not.

noncontroversial information (e.g., data on immunizations and participation in early intervention programs) while school district staff work with the service agencies to develop security features.

Several other issues have emerged during discussions of data gathering in Fort Pierce. In particular, the data that the school district would like to track are different from those that the health center normally tracks with its computer system. As a result, the district lacks accurate school and student data regarding services provided. The high student mobility rate at Fort Pierce—38 percent during 1992-93—also makes program analysis over time difficult because the population changes.

A Planning and Implementation Checklist

The Core Planning Group

[] Have you expanded your initial planning group to include:

- [] a range of stakeholders?
- [] top-level decision makers and front-line practitioners?
- [] key players within your community?

[] Have you made an effort to address the communication gap between professionals from different fields on the planning committee?

Community Needs Assessment

[] Have you designed a needs assessment that will tell you:

- [] the major concerns and priorities among stakeholders?
- [] major issues and potential conflicts to anticipate?
- [] available resources, including sources of potential funding and in-kind support?

[] Have you talked with staff in each school that will be affected to gauge support?

[] Have you surveyed or talked to students about their health concerns and needs?

[] Have you conducted focus groups, town meetings, or a public opinion poll?

Community Relations

Have you:

- [] met with elected officials and religious supporters who are likely to support your program, to explain the project and outline responses to community concerns?
- [] gained support from other community groups (PTAs, the Junior League, the League of Women Voters, etc.)?
- [] invited parents to tour the clinics to answer questions, assuage their fears, address misperceptions, and encourage enrollment?
- [] discussed how your community is likely to react to each element of your program design, and developed responses to any concerns?
- [] chosen and trained a credible, articulate, accessible person to act as your official spokesperson?
- [] developed a few powerful, simple messages that support your program? contacted editorial writers, editors, and reporters to discuss your message?

[] made the public aware of your program's positive aspects?

[] reported your efforts back to community members on a regular basis (e.g., quarterly)?

Services

Have you:

[] defined your target group (elementary, middle, or high school students) and thoroughly discussed the reasons for targeting this group that are specific to your community?

[] discussed the pros and cons in your community of providing services to students, families, or the entire community?

[] discussed the pros and cons in your community of making services school linked or school based?

What mix of services will your program offer?

[] health screenings
[] immunizations
[] health education
[] counseling
[] pregnancy testing
[] birth control distribution
[] Head Start screenings
[] dental care
[] physical exams
[] chronic illness care
[] minor acute care
[] case management
[] family planning
[] home visits
[] WIC/nutrition services
[] other

How will your health program integrate with education?

[] classroom presentations, health-related classes
[] curriculum co-design
[] clinic-based special presentations or student internships

Funding and Reimbursement

How will collaborators in your program divide financial responsibility for:

[] the facility
[] equipment and supplies
[] operating and administrative expenses
[] staff salaries
[] custodial services
[] malpractice insurance

Who will be responsible for obtaining reimbursement from Medicaid and private insurers?

Staffing and Management

Which of the following staff positions fit your project best, and why?

[]	physician	[]	nurse practitioner
[]	LPN	[]	physician assistant
[]	mental health professional	[]	clinic coordinator
[]	school nurse	[]	dentist, dental assistant
[]	health educator	[]	WIC/nutrition staff
[]	case manager	[]	student interns

Have you considered:

- [] what type of work background you want prospective staff to have?
- [] what type of orientation you will provide for new staff?
- [] how to coordinate clinic staff with school nurses?
- [] how to coordinate health and school staff?
- [] what form of staff supervision will meet your specific needs?
- [] how much autonomy on-site clinic staff should have, and what oversight system will work best for your program?

Referrals and Appointment Schedules

Who (if anyone) will serve as gatekeeper for referrals to your program?

What are the creative, low-cost ways in which you can encourage self-referrals and community-based referrals?

- [] coordinate with coaches for sports physicals
- [] offer extended hours at the beginning and end of the school year
- [] make presentations in classrooms or to community groups
- [] visit feeder schools or summer sports camps to distribute flyers
- [] send mailings to parents and community members
- [] offer tours of the clinic
- [] publicize services on local cable television channels, including those that broadcast in languages other than English
- [] publicize services through free public service announcements on radio stations, notices or exhibits at libraries, participation in county fairs or other community events, etc.

Which outside providers in your community will take referrals from your school-linked or school-based program?

Confidentiality and Parental Consent

What are the local or state laws in your community that affect confidentiality? (What services can you give and what medical conditions can you treat that don't require parental consent? What services do require parental consent and information?)

Whose confidentiality rules (those of the school district or those of the health care provider) will your program use?

Have you designed or obtained:

- [] a consent form or policy that will allow educators and health professionals to share information as needed?
- [] a parental consent or "enrollment" form or policy, if required by law or desired by program staff

Self-Assessment and Evaluation

What procedures will your program use for self-assessment?

- [] periodic review of patient charts by a staff supervisor (if so, how often and by whom?)
- [] staff training in management or team techniques
- [] regular meetings of all staff to discuss quality issues

What data will you track to inform decisions about ongoing changes and adjustments?

- [] number of students who use the school-health program
- [] services provided
- [] student, parent, and community satisfaction with services
- [] patterns of use
- [] other

Who will be responsible for data collection?

How will you involve *all* staff—both education and health professionals—in assessing the program?

Are your procedures for self-assessment in place and working? If not, what will it take to achieve this?

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Modification, Expansion, and Sustainability

A school-health program's issues and strategies change over time as the linkage moves from establishing services as originally planned to fine-tuning the program in response to students' needs. As planning and implementation give way to long-term operation, program leaders face the challenges of modifying the program and working toward long-term financial stability. Both are discussed below.

Modifying the Program

Typical modifications to school-health linkages that occur over time as a natural part of the maturing process include changes in goals, services, and staffing.

Changing Goals and Services

Typically, as programs become more established and students get to know and trust the medical staff, more students use the center and it faces new demands. In several school-based cases, the health program's role shifted from an emphasis on walk-in access to providing a more structured environment with more pre-planned appointments; this allows staff to provide more individualized and comprehensive services. "If you're always stamping out fires, you never get that preventive edge," a nurse explained. By adding the structure of appointments and preventive care, clinic staff were better able to ensure that each child receives the same basic package of health care in addition to specialized attention.

Several other sites reported that their school-health linkages began as an attempt to reduce pregnancy rates among adolescents but as this goal was achieved, the programs identified other needs, such as education on nutrition and drug or alcohol abuse, and branched out into these services. Some sites also reported that as their programs moved in these directions mental health services became more integral, as did ties with outside agencies that could provide the more comprehensive services.

Front-line clinic staff also realize that as their programs moved into full-blown operation, some of the important services offered by the school-health program were not necessarily traditional health care services. For example, clinic staff found that they had to teach students how to make—and keep—appointments at the school health program and with outside providers. Clinic staff also reported that they began to spend more time on referrals to health maintenance organizations when they realized that their intervention helped students get services more quickly.

Staffing Changes

Staffing needs frequently change over time as programs recognize new needs, expand services, or encounter problems. Most often, programs try to (1) turn part-time nurse-practitioner or LPN positions into full-time positions so they can serve more students, (2) hire new or additional mental health counselors to offer more comprehensive services, or (3) add a coordinating position to improve relationships with the school and other care providers. Most sources said they knew in advance that these extra staffing positions were needed but they lacked adequate funding.

Sometimes, however, staffing needs arise during implementation that planners didn't anticipate. Comprehensive school-based clinics at one site struggled during their first year because there was no lead nurse position; no one on the staff

was responsible for disseminating information, fielding calls from the public, or coordinating interaction with other players. There was no single point of access or accountability to the school, and no staff member designated for solving referral problems. Planners responded by adding a community health nurse to the staff of each clinic as a coordinator, and this change seems to have solved the problems. Another urban site with a much smaller program found it necessary to add a coordinator to free up the limited staff to concentrate on providing primary care. "If you're trying to put together a continuum of care, primary care is only one piece," explained an administrator. "A [nurse] can't be expected to be a liaison with other community groups, do evaluation, and do outreach. That's not the best use of them."

Changes in staffing or management can generate turf problems, however. The clinics that decided to use community health nurses as coordinators ran into problems with county guidelines that said such a central decision-making role must constitute a lead position. This touched off a power struggle among other care providers already in the clinics. (The community health nurses were chosen as coordinators because organizers felt that their experience in social work and administration as well as nursing would give them greater awareness of the environmental factors that affect school-health linkages, whereas nurse practitioners were believed to have a more purely medical orientation.) Although this change occurred more than four years ago, and most of the friction has subsided, evidence of the turmoil remains in the fact that while county administrators refer to the position as "lead nurse," a nurse who has the coordinating role refers to herself simply as "the community health nurse" and downplays her official role as a clinic leader.

High turnover among certain types of health staff, particularly mental health professionals, caused staffing changes and problems at some sites. A center operated by one of the sites in the sample had gone for most of the school year without one of its two planned mental health counselors because of staff turnover, which restricted the services the program could provide.

Expanding the Program

A new set of issues come into play when programs expand services from one school or site to several. Of the sites in the sample, Multnomah County's school-based health centers had the most experience in expanding services (from one school in 1986 to ten by the end of 1995). Sources at this site offered the following advice:

- Multiple sites require extra administrative infrastructure. "We're struggling as we grow [to decide] how many managers we need and what is a reasonable number of sites [to manage] per person," explained one source. Portland planners have decided that one manager can effectively oversee about six or seven sites.

- New sites need intensive attention for 12 to 18 months to make sure that they settle into a routine and are accepted by the school and community.

- Learn from past experiences. In Portland, planners learned to be more precise in estimating space needs and to conduct more community outreach to avoid misunderstandings about clinic services.

- The way in which the program expand may affect participant investment. Multnomah County's program expanded in bunches of two or three sites at a time, not singly, because political support and money was available for quick growth.

But planners now say that successive collaborators didn't get the same "trial by fire" that the first group did; they didn't have the bonding experience of facing problems and devising solutions, and the initial process of discovery had become an established system. As one planner recalled, "The next group of principals was *told* this was a great idea; they weren't *convinced*."

- To make the program as comprehensive as possible as it expands, try to promote continuity of services among sites or among levels of sites. Portland, which began with high school clinics and expanded to middle and elementary schools, hopes that the middle- and elementary-level programs will be more preventive and will focus more on teaching children how to gain access to health services, while the secondary sites continue to focus on primary care and pregnancy prevention. As the program expands, the health care provider plans to have high school clinic staff act as consultants to the middle school providers, and to hold joint staff meetings, to promote the view that school-health linkages are a combined effort.

Working Toward Long-Term Financial Sustainability

For school-health programs, long-term financial strength comes from the ability to survive changes in funding and obtain stable, sufficient funding.

Surviving Changes in Funding

Because stable, long-term funding for school-health linkages is so hard to find, many programs face significant changes in financial support after the first few years of implementation. At many sites in the sample, local funding sources were reducing their commitment and, in many cases, federal funding was scheduled to expire soon. At one site, the state had reduced its financial commitment in the school-based program from 80 percent of the cost in 1993 to 65 percent in 1994. The health center director had great doubts about whether the program would be able to continue if the school district stopped its contribution and the program was forced to rely on reimbursements to support itself; yet district administrators feared that change was inevitable. At another site, administrators were concerned that the school-linked program's three-year federal grant was set to expire at the same time that the state is considering requiring Medicaid recipients to enroll in managed-care systems, a change that could make it more difficult for the school-health program to obtain income through reimbursements.

Like any other program, school-health linkages survive changes in funding by diversifying their funding sources or redesigning services. A school-linked program that provided sex education at no charge, for example, lost its funding for materials and began to charge for these services. No schools have signed up to continue the classes since the funding change, although school staff say they would like to if they had money to spare. Until this matter is resolved, the health care provider appears to be providing some sex education services at no cost, in addition to health screenings and basic health care already provided without charge. Several other sites reported that they are pursuing Medicaid reimbursements more aggressively to generate more revenue. But sources at all sites advise planners of new school-health linkages to think ahead and try to avoid these problems by not relying on single-source, short-term funding.

Stable, Sufficient Funding—Where Does it Come From, and How Do You Get It?

Everyone agrees that sufficient funding for school-health programs is hard to find—and a stable mix of funding is even more elusive.

The most common approaches to long-term sustainability are strategies for increasing reimbursements from Medicaid, private insurers, and managed care organizations.

Obtaining reimbursement from Medicaid and private insurers. All except one site in the sample provided services at no charge to all students, regardless of insurance status, so obtaining reimbursements plays a big role in long-term funding for these school-health linkages. The amount of program costs collected through reimbursements ranged from approximately 7 percent to 46 percent of programs' annual budgets—not a sufficient amount to maintain them without additional support. Sources attribute the low rates of reimbursement to several issues that C/MHCs themselves face in treating patients, including confidentiality constraints, paperwork burdens, and fluctuations in eligibility:

- Medicaid generally will not pay for services for a Medicaid recipient that are available to other children without charge. The Health Care Financing Administration's long-standing rule is that a provider must either bill other individuals receiving the services or at least bill the third-party payers of other individuals who have third-party coverage. Providers may not bill the Medicaid agency alone, except in the case of Title V services and services to handicapped children under Individualized Education Plans (IEPs) and Individualized Family Service Plans (IFSPs) under the Individuals with Disabilities Education Act (IDEA).

- Medicaid eligibility fluctuates for many students. At one urban, school-based site, an estimated 15 to 20 percent of the students served by the program go on and off medical assistance several times during the course of each year.

- When a student or other Medicaid recipient has private insurance in addition to Medicaid, Medicaid usually requires health programs to pursue payment from families and insurers first; but most families served by these programs are too poor to pay—and insurers require additional paperwork, placing an administrative burden on school health staff. Medicaid makes an exception for preventive pediatric care, including early and periodic screening and diagnosis services. In these cases, the medical provider can bill Medicaid first. Medicaid will generally pay the provider and seek reimbursement from the insurer. This is referred to as "pay and chase." The pay and chase method may be used for treatment whenever it is determined that requiring the health care provider to seek reimbursement from the insurer will discourage provider participation.

- Statements from insurers typically are mailed to a student's home. Clinic staff are reluctant to bill for reimbursement of some services if it would jeopardize a student's confidentiality. For Medicaid-eligible students, confidentiality can be jeopardized by the fact that many students do not know their Medicaid number and must ask a parent for it—which reveals that the student is seeking health services. This issue is especially problematic for adolescents, who may not want to discuss health concerns with their parents.

Reimbursement and managed-care providers. The problems listed above become more complicated in communities that require Medicaid participants to enroll in managed-care health plans (i.e., primary provider systems or health maintenance organizations). As noted earlier, a growing number of states have such

requirements, including two in the sample (Indiana and Michigan). These sites report obstacles to coordinating with managed-care providers to obtain reimbursement, including state-level policies that prevent C/MHCs and school-based clinics from qualifying as managed-care providers, and refusal by managed-care plans to turn over payments to school-based centers or C/MHCs for services provided to students who belong to managed-care plans.

These restrictions manifest themselves in a variety of ways. For example, nurses in the Cherry Street, Michigan, school-based clinics cannot provide EPSDT screenings for students who are enrolled with managed-care providers unless those providers have authorized the program to conduct screenings or other routine checks. Approximately 20,000 students are eligible for the screenings, so Cherry Street staff are negotiating with providers to obtain authorization. So far, two clinics have granted authorization and two have refused. Clinic staff notify parents whose children are enrolled with providers who do not grant authorization, and the clinic encourages parents to make appointments with those providers for physical exams or EPSDT screenings.

Reimbursement issues are further complicated by busing and school choice arrangements, which remove students from their neighborhoods to attend specific schools. Medicaid patients in Indiana, for example, often chose managed-care providers that are located in their neighborhoods. But in Indianapolis, which has mandatory busing requirements, most students do not attend school in the neighborhood where they live. Chosen providers often are reluctant to consent to treatment by school-health staff because they have not seen the student in several years and are not familiar with his or her medical history. Programs like HealthNet, however, cannot bill Medicaid for services without the chosen provider's consent. As a result, HealthNet treats these patients at the school clinic but does not receive reimbursement from Medicaid.

Finally, Medicaid managed care complicates the paperwork required for reimbursement, because a C/MHC must file different forms for each HMO from which it requests reimbursement. At one site, the proliferation of forms under Medicaid managed care discouraged a school-linked clinic from seeking reimbursement because staff time was too limited.

There are no easy solutions to these problems. In some cases, the combined challenges to obtaining reimbursement lead programs to avoid the issue altogether. In other cases, sites are working to obtain state waivers that would facilitate the reimbursement of school-linked services to Medicaid recipients or have negotiated arrangements with area managed-care providers that allow school-linked or school-based health programs to treat students if they have not been examined by a managed care physician in a specified number of years.

Appendicies

Appendix A: Glossary of Health and Education Terms **A-3**

Appendix B: Reference Materials **A-5**

Appendix C: Contact Information **A-20**

Appendix D: Profiles of Selected Sites **A-34**

Cherry Street Health Center and Henry Paideia Academy
Grand Rapids, Michigan A-35

Clinica Adelante and the Queen Creek School District
Queen Creek, Arizona A-42

Fort Pierce Family Service Center and Fort Pierce Elementary School
Fort Pierce, Florida A-48

HealthNet, Inc., and Bridges to Success at School 50
Indianapolis, Indiana A-55

Konawa Community Health Center and Pleasant Grove School
Konawa, Oklahoma A-61

Logan Heights Family Health Center and The Place
San Diego, California A-67

Multnomah County Health Department and Jefferson High School
Portland, Oregon A-73

Southeast Lancaster Health Services and King Elementary School
Lancaster, Pennsylvania A-80

Valley Wide Health Services and Sierra Grande School
Blanca, Colorado A-86

Appendix A:
Glossary of Education and Health Terms

Acute care

Care of illnesses in which the symptoms or discomfort develops very quickly—over only a few hours or days.

BPHC

The Bureau of Primary Health Care is located in the Health Services and Resources Administration—one of eight agencies of the Public Health Service within the U.S. Department of Health and Human Services. BPHC's mission is to increase access to comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations. BPHC provides funding for community and migrant health centers, programs that provide health care for the homeless, primary health care programs in public housing developments, school-based health centers, and programs to provide early intervention services to people who are HIV-positive. BPHC also supports the placement of primary care providers in underserved areas through the National Health Service Corps.

C/MHCs

Community and migrant health centers. Community health centers provide comprehensive primary health care to medically underserved, vulnerable populations. Health centers are located in communities across the country where there are financial, geographic, or cultural barriers that limit access to primary health care for a substantial portion of the population. Migrant health centers provide comprehensive primary health care to migrant and seasonal farm workers and their families at sites across the country. Clinicians in these health centers are often bilingual and bicultural and are familiar with the complex health problems faced by farm workers and other vulnerable populations. Of the more than 700 organizations receiving federal funding through the C/MHCs or the BPHC's Health Care for the Homeless program, approximately 250 provide school health services.

Chronic illness care

Care of illnesses in which the symptoms or ill-health findings last for months or years.

Co-located services

See school-based health services

Comprehensive health care

Care that includes primary medical services as well as related services that support overall good health; often includes mental health counseling and dental care and supplemental services such as nutrition counseling and social services.

Community health nurse

A nurse who works in an outreach position for a community-based health provider and often has experience in linking health and human services.

EPSDT

The Early and Periodic Screening, Diagnostic, and Treatment program is Medicaid's preventive health care program for children.

ESEA

The Elementary and Secondary Education Act of 1965. The Act authorized several initiatives to improve the education of at-risk students, including the Title I program.

Licensed practical nurse (LPN)

A nurse who is trained and licensed to provide nursing services under the supervision of registered nurses or doctors.

Nurse practitioner

A registered nurse who has obtained advanced training in one of several primary care areas. State regulations vary, but these nurses usually are authorized to provide primary and preventive health care, conduct physical exams, monitor patients with chronic illnesses, provide nutrition and health counseling, and make referrals to other health care providers. In some states, nurse practitioners can also prescribe medications and work without supervision.

Physician assistant

A person who is authorized to conduct physical exams, provide counseling, and prescribe some medications under supervision by a physician.

Primary health care

First-line health care provided in an office or clinic setting by a provider who takes responsibility for the patient's health. Primary care providers may refer patients to specialists for a more in-depth diagnosis and specialized treatment.

STD

An acronym referring to a sexually transmitted disease.

School-based health services

Medical, psychosocial, or dental services delivered by non-school personnel on school grounds (also sometimes called *co-located services*). School-based programs bring services to students by locating them within the school building or in a separate building on school grounds. Services may be available on a full- or part-time basis. Most school-based programs also have special referral and/or transportation arrangements with service sites located off school grounds for services not offered at the school.

School-linked health services

Medical, psychosocial, or dental services provided through special referral arrangements between schools and other agencies. A school-linked program may provide transportation to and from the school and other agencies or establish special relationships with other providers that enable them to make appropriate referrals and schedule appointments on behalf of students and their families. The services may be available on a full- or part-time basis.

Title I

A program authorized by the Elementary and Secondary Education Act, later replaced and amended as Chapter 1 (and reauthorized by the Improving America's Schools Act of 1994, which changed the program's name back to Title I). This program, the mainstay of federal efforts to improve the education of at-risk students, provides approximately $7 billion for services that range from supplemental instruction to staff development to comprehensive schoolwide programs.

Title XI

A program authorized by the Elementary and Secondary Education Act (ESEA). This program allows local education agencies to use up to 5 percent of their ESEA funds to develop, implement, or expand a coordinated services project, defined as a comprehensive approach to meeting the educational, health, social service, and other needs of children and their families through a community-wide partnership that links public and private agencies providing services through a coordination site at or near a school.

Appendix B:
Reference Materials

This appendix contains sample forms used by an urban, school-based clinic at one of the sites profiled for this idea book. Items include:

- A single **consent form** that authorizes school-based clinic staff to provide health and counseling services to students, exchange information with school nurses, and bill Medicaid and other insurance carriers
- A form used by the school nurse to **refer students to the school-based clinic** for services, which includes a mechanism to provide feedback to the school nurse in order to facilitate coordinated services
- A form used by the school-based clinic to **refer students to outside providers**, which includes a mechanism to provide feedback to the school-based clinic with the patient or parent's consent
- Sections of a **student health evaluation** used by the program planners to assess needs and design services

This appendix also contains a chart clarifying the range of essential and optional services of school-based health centers. The chart, accompanied by a set of principles for school-based health centers, originally appeared in Ingredients for success: Comprehensive school-based health centers, by C. Brellochs and K. Fothergill. This report on the 1993 National Work Group Meetings was published by the School Health Policy Initiative in 1995. The chart is reprinted here by permission from the author.

School-Based Health Center Consent Form

Student Name

Date of Birth

I hereby authorize the School-Based Health Center (SBHC) located at Jefferson High School to provide health and counseling services to:

☐ my child ☐ me*

I authorize the exchange of information between the SBHC and the ESD (Educational Services District) School Nurses. This release of information shall be in effect throughout the student's high school education unless revoked.

Signature

Relationship Date

*Oregon State law requires a parent or guardian's signature for students under 15 years old except for family planning and Sexually Transmitted Disease (VD) services. ORS 109.610, 109.640, ORS 109.675

Insurance Information

Enrolled students are not charged for services received at the Health Center. Medicaid and other insurance carriers may be billed. Please sign and complete the information below. We will not pursue payment from students or their families.

AFS Medicaid Recipient I.D. Number:

Social Security Number:

Insurance Company: Phone: ( )

Address:

City: State: Zip:

Name of Policyholder:

Relationship to student (father/mother/spouse, etc.):

Policy #: Group #:

Consent to Release Information To My Insurance Carrier

I authorize release of medical and related information, including alcohol, reportable communicable disease information, drug abuse, and mental health records obtained in the course of diagnosis and treatment to my health insurance company (or other third party payor) for the purpose of obtaining payment for service rendered. This authorization excludes sexually transmitted disease diagnosis or HIV related information. Authorization may be withdrawn at any time by written notification.

Parent, Guardian, Responsible Party, Interpreter (if applicable) Client (15 years or older)

G-199 6/92

PLACE STAMP HERE

RETURN TO:

Jefferson School-Based Health Center
5210 N. Kerby
Portland, Oregon 97217

BEST COPY AVAILABLE

SCHOOL HEALTH SERVICES

MULTNOMAH EDUCATION SERVICES DISTRICT

REFERRAL FOR SCHOOL-BASED HEALTH CENTER SERVICES

Student Name _____ DOB _____ Date _____

Reason for Referral:

Vital signs: Temp _____
BP _____
HR _____
RR _____

Appointment needed when: _____

Other health care source/provider: _____

If client is under 15 years of age and needs parental consent please list name and phone number where consent can be obtained: _____

Signed _____
(SHS Nurse) Date

If student is 15* years or older and there is no conset card on file in SBHC, the following must be signed:

I authorize the exchange of information between Multnomah Education Service District nurses and the School Based Health Clinic.

Signed _____
(Student) Date

FEEDBACK TO SCHOOL NURSE

Appointment date:

Diagnoses (if applicable):

Treatment:

Plans for Follow-up:

Additional Information:

Signed _____ Date Returned _____
(SBHC Nurse/Nurse Practitioner)

*If student is 14 years and has no signature card on file in SBHC, parental consent must be obtained except for family planning, sexually transmitted disease, mental, emotional, or chemical dependency services. (ORS 109.610 - 109.640 - 109.675)

SHS/Referral.sbc
White - SBHC Chart; Yellow - Returned to SHS RN

BEST COPY AVAILABLE

MULTNOMAH COUNTY
DEPARTMENT OF HUMAN SERVICES
HEALTH DIVISION

School Based Health Center | **HEALTH REFERRAL**

Multnomah County will not make payment for services rendered.

Date: _____ Referring Provider: _____ Referring Provider #: _____

SECTION A REFERRAL INFORMATION

FROM: **TO:**

❑ **Cleveland School-Based Health Ctr.** ❑
Cleveland High School
3400 SE 26th Avenue
Portland, Oregon 97202 / 248-3350

❑ **Grant School-Based Health Ctr.** ❑
Grant High School
2245 NE 36th Avenue
Portland, Oregon 97212 / 248-3372

❑ **Jefferson School-Based Health Ctr.** ❑
Jefferson High School
5210 N. Kerby Avenue
Portland, Oregon 97217 / 248-3360

❑ **Madison School-Based Health Ctr.** ❑
Madison High School
2735 NE 82nd Avenue
Portland, Oregon 97218 / 248-3382

❑ **Marshall School-Based Health Ctr.** ❑
Marshall High School
3905 SE 91st Avenue
Portland, Oregon 97266 / 248-3370

❑ **Parkrose School-Based Health Ctr.** ❑
Parkrose High School
11717 NE Shaver Street
Portland, Oregon 97220 / 248-3392

❑ **Pivot School-Based Health Center** ❑
2508 NE Everett Street
Portland, Oregon 97232 / 248-3352

❑ **Roosevelt School-Based Health Ctr.** ❑
Roosevelt High School
6941 N. Central Street
Portland, Oregon 97203 / 248-3111

SECTION B – OUTSIDE REFERRAL INFORMATION

REFERRED TO

ADDRESS

CITY ST ZIP PHONE

SECTION C – CLIENT INFORMATION

PATIENT'S ID #

PATIENT'S NAME DOB

ADDRESS

CITY ST ZIP PHONE

Insurance: _____ ID # _____

Group # _____ Effective: __ __ / __ __ / __ __

Insurance: _____ ID # _____

Group # _____ Effective: __ __ / __ __ / __ __

SECTION D – PROVIDER INFORMATION

Reason for referral and outside provider findings (or send written report):

PLEASE RETURN A COPY OF YOUR EVALUATION, FINDINGS, STUDIES, AND RECOMMENDATIONS TO THE REFERRING MULTNOMAH COUNTY FACILITY CHECKED IN SECTION A ABOVE
Thank you.

SECTION E – CLIENT CONSENT

I consent to the release of the above information, including medical, dental, alcohol, drug abuse & mental health records obtained in the course of my diagnosis and treatment. I understand that such information cannot be released without my consent, except in a medical emergency, audit or court order. This release complies with Federal and State law.

_____ Date

_____ Signature of Patient / Parent / Legal Guardian (Circle One)

POR-771 Rev 8/90 THE MULTNOMAH COUNTY DEPARTMENT OF HUMAN SERVICES OFFERS EQUAL OPPORTUNITY IN SERVICES AND EMPLOYMENT

BEST COPY AVAILABLE

Multnomah County Health Department
Student Health Evaluation

MARKING INSTRUCTIONS

- **Use No. 2 pencil only.**
- **Fill bubbles completely.**
- **Erase changes cleanly.**
- **Make no stray marks in this booklet.**

INCORRECT MARKS ⊘ ⊗ ◒ ⊙ **CORRECT MARK** ●

Which school do you go to?

- Roosevelt
- Jefferson
- Marshall
- Madison
- Grant
- Cleveland
- Parkrose

To all students:

Your help today in filling out this survey is very important to us. This survey will help us to better understand the thoughts and concerns that students in your school have about their health and health care.

This is not a test. **There are no right or wrong answers. Your name will not be on this survey.** ***No one will ever be able to find out how you answered any question.***

Please take time to answer each question carefully and truthfully. Sometimes you will find that the answer you give will cause you to skip over some questions. This will take you to the next question that applies to you. Please follow these skips carefully.

Thanks for your help!

SECTION A

In this first section, we would like to learn about how the students in your school get their health care.

1. **How many times have you seen a nurse or doctor during the past school year for any reason?**

   - ○ None
   - ○ One time
   - ○ Two times
   - ○ Three or more times

2. **When did you last have a *routine* physical exam or check-up on your health?** ***(Not because you were sick.)***

   - ○ Within the past 12 months
   - ○ 1 - 2 years ago
   - ○ Over 2 years ago
   - ○ Never
   - ○ Don't remember

3. **Where do you *usually* go for health care?** ***(Mark only one.)***

   - ○ Family Doctor
   - ○ Community Clinic
   - ○ Emergency Room
   - ○ School Based Health Center
   - ○ No where
   - ○ Other

4. **What kind of health insurance do you have?**

   - ○ No insurance
   - ○ Private health insurance
   - ○ Medicaid/Medical card
   - ○ Don't know

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5. **During the past school year, was there a time when you needed to see a nurse or doctor but *did not go*?**

   ○ Yes
   ○ No – *if No, skip to Question #7*

6. **What kept you from going to see a nurse or doctor? *(Mark all that apply.)***

   ○ It cost too much
   ○ I didn't have a regular nurse or doctor
   ○ I didn't want my parents to know
   ○ I was too busy
   ○ The hours were not good for me
   ○ It was hard to get an appointment
   ○ I was afraid
   ○ I didn't have insurance
   ○ I had no one to take me there
   ○ I didn't know how to get an appointment
   ○ Other _____

7. **How is your health?**

   ○ Excellent
   ○ Good
   ○ Fair
   ○ Poor

8. **In the past 30 days, how many days of school did you miss because you were *sick*?**

   ○ None
   ○ 1 - 2 days
   ○ 3 - 4 days
   ○ 5 days or more

SECTION B

There is a School Based Health Center that provides health care for students in many Portland/Parkrose high schools. It is separate from the school nurse. In this section, we would like to know about how students use the School Based Health Center.

9. **During the past school year, where did you go for each of the following reasons? You may have gone to more than one place for each reason. *(Mark all that apply.)***

	Didn't need care	*Needed care; didn't see anyone*	*School Based Health Center*	*Family Doctor*	*Community Clinic/Kaiser*	*Emergency Room*
Check-up or sports physical						
Injury/accident	○					○
Illness						
Birth control/condoms	○					○
Sexually transmitted diseases						
Pregnancy test	○					○
Female exam						
Drug/alcohol problem	○					○
Immunizations (shots)						
Personal/emotional problem	○					

10. **Have you ever used *any* School Based Health Center in a Portland/Parkrose high school?**

    ○ Yes
    ○ No – *if No, skip to Question #12*

11. **When did you *first* use any School Based Health Center in a Portland/Parkrose high school?**

    ○ 9th grade
    ○ 10th grade
    ○ 11th grade
    ○ 12th grade

12. **How did you *first* hear about the School Based Health Center in *this* school? *(Mark all that apply.)***

    ○ I've never heard of the School Based Health Center
    ○ Brochure or letter
    ○ Teacher or School Counselor
    ○ Friend
    ○ School Nurse
    ○ New Student Orientation
    ○ Someone came to class to tell us about it
    ○ School Assembly
    ○ Other

13. **Have you used the School Based Health Center at *this* school?**

- ○ Yes – *If Yes, skip to Question #16*
- ○ No
- ○ I don't know

14. **If you *haven't* used this School Based Health Center, what are your reasons? *(Mark all that apply.)***

- ① I didn't know there was a School Based Health Center
- ② I don't need to go
- ③ I go somewhere else
- ④ I'm afraid my parents would find out
- ⑤ My teachers would not let me out of class
- ⑥ I worry about my privacy (it doesn't feel safe there)
- ⑦ I couldn't get an appointment
- ⑧ I'm afraid of what it will look like to other people if I go there
- ⑨ Other _____

15. **Fill in the number below that matches the *most important reason* from above for *not* using the School Based Health Center.**

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

If you haven't used the School Based Health Center, skip to Page 4, SECTION C now.

16. **When did you *first* use the School Based Health Center at this school?**

- ○ 9th grade
- ○ 10th grade
- ○ 11th grade
- ○ 12th grade

17. **During the past school year, how many times have you used the School Based Health Center at this school?**

- ○ Never
- ○ One time
- ○ Two times
- ○ Three times
- ○ Four times
- ○ Five or more times

18. **During the past school year, how often have you gone to the School Based Health Center for....?**
(Mark one for <u>each</u> reason.)

	Never	*1 or 2 times*	*3 or 4 times*	*5 or more*
Check-up or sports physical				
Injury/accident				
Illness				
Birth control/condoms				
Sexually transmitted diseases				
Pregnancy test				
Female exam				
Drug/alcohol problem				
Immunizations (shots)				
Personal/emotional problem				

19. **The staff at the School Based Health Center will sometimes ask students to come back for follow-up visits to check their progress. Have you returned to the School Based Health Center for follow-up visits when you were asked to?**

- Always
- Sometimes
- Never
- I have never been asked to come back for a follow-up visit

20. **Why do you use the School Based Health Center? *(Mark all that apply.)***

- The hours are good for me
- It is easy for me to get there
- My privacy will be protected (it feels safe there)
- I like the staff (they understand my needs and problems)
- I get good care there
- My parents want me to go there
- I do not have to pay
- I do not have to wait a long time for an appointment
- My parents don't have to know I go there
- It's easy to make an appointment
- I don't have insurance
- I have no where else to go

21. **Fill in the number below that matches the *most important* reason from above for going to the School Based Health Center.**

22. The last time you visited the School Based Health Center, how long did it take you to get in for:

Birth control
- ○ Didn't need it
- ○ The same day
- ○ A few days
- ○ About a week
- ○ More than 1 week
- ○ Never got an appointment

Personal or emotional problem
- ○ Didn't need it
- ○ The same day
- ○ A few days
- ○ About a week
- ○ More than 1 week
- ○ Never got an appointment

Illness/Injury
- ○ Didn't need it
- ○ The same day
- ○ A few days
- ○ About a week
- ○ More than 1 week
- ○ Never got an appointment

23. Do your parents know you use the School Based Health Center?

- ○ Yes
- ○ No
- ○ Don't know

24. Do your parents approve of your using the School Based Health Center?

- ○ Yes, for everything – *if Yes for everything, skip to Question #26*
- ○ Yes, for some things
- ○ No
- ○ Don't know

25. What services do your parents *not* want you to use at the School Based Health Center? *(Mark all that apply.)*

- ○ Physical exam/check-up
- ○ Injury/accident
- ○ Illness
- ○ Birth control
- ○ Sexually transmitted diseases
- ○ Pregnancy test
- ○ Drug/alcohol problem
- ○ Immunizations (shots)
- ○ Personal/emotional problem
- ○ Don't know

26. In general, how satisfied are you with the services you have received at the School Based Health Center?

- ○ Very satisfied
- ○ Somewhat satisfied
- ○ Satisfied
- ○ Somewhat unsatisfied
- ○ Not satisfied

27. If you have used the School Based Health Center for a personal or emotional problem, how satisfied are you?

- ○ I have never used the School Based Health Center for a personal/emotional problem
- ○ Very satisfied
- ○ Somewhat satisfied
- ○ Satisfied
- ○ Somewhat unsatisfied
- ○ Not satisfied

28. If there *wasn't* a School Based Health Center at this school, where would you get the care you now get from the Center? *(Mark all that apply.)*

- ○ Family doctor
- ○ Community clinic
- ○ Emergency room
- ○ Kaiser
- ○ No where
- ○ Don't know
- ○ Other

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ESSENTIAL & OPTIONAL SERVICES OF COMPREHENSIVE SCHOOL-BASED HEALTH CENTERS (SBHCS)

HIGH SCHOOL SERVICES	ESSENTIAL	OPTIONAL (Preferred)	OPTIONAL (As needed)
MEDICAL SERVICES			
Comprehensive medical and psychosocial histories	◆		
Immunizations	◆		
Comprehensive physical examinations per EPSDT guidelines	◆		
Developmental assessment	◆		
Assessment of educational, achievement, and attendance problems	◆		
Vision screening	◆		
Hearing screening	◆		
Dental assessment	◆		
Referral for dental care	◆		
Dental care		◆	
Diagnosis and treatment of minor medical problems	◆		
Diagnosis and treatment of acute medical problems	◆		
Management of chronic medical problems	◆		
Prescription of medications for minor medical problems	◆		
Prescription of medications for acute medical problems	◆		
Prescription of medications for chronic medical problems	◆		
Dispensing of medications for minor medical problems	◆		
Dispensing of medications for acute medical problems	◆		
Dispensing of medications for chronic medical problems			◆
Laboratory testing	◆		
Referral to medical specialty services	◆		
Twenty-four hour coverage	◆		
Gynecological/Urological care	◆		
Family planning	◆		
Family planning referrals	◆		
Prescriptions for contraceptives	◆		
Dispensing of contraceptives		◆	
Referrals for contraceptive prescriptions	◆		
Condom availability	◆		

HIGH SCHOOL SERVICES	ESSENTIAL	OPTIONAL (Preferred)	OPTIONAL (As needed)
Pregnancy testing	◆		
Pregnancy testing referrals	◆		
Options counseling	◆		
On-site prenatal care		◆	
Prenatal care referrals	◆		
Well child care of students' children			◆
Referrals to well child care	◆		
On-site STD treatment	◆		
Referral for STD treatment	◆		
HIV testing and counseling	◆		
Referral to HIV pre/post test counseling	◆		
On-site HIV/AIDS treatment		◆	
Referral for HIV/AIDS treatment	◆		
Case management	◆		
HEALTH EDUCATION/PROMOTION			
One-on-one patient education	◆		
Group/targeted education at SBHC	◆		
Sample topics:			
Smoking cessation			
Teen parenting classes			
Weight reduction seminars			
Family and community health education	◆		
Supplemental classroom presentations & resource support for comprehensive health education	◆		
Sample topics as appropriate:			
STD/HIV/AIDS education			
Pregnancy prevention			
Drug use prevention			
Intentional & unintentional injury prevention			
Chronic conditions (e.g. asthma)			
General parenting skills			
MENTAL HEALTH SERVICES			
Individual mental health assessment, treatment, and follow-up, including	◆		
Physical/sexual abuse i.d. & referral	◆		
Substance abuse assessment	◆		
Substance abuse counseling	◆		
Substance abuse referrals	◆		
Group and family counseling	◆		

HIGH SCHOOL SERVICES	ESSENTIAL	OPTIONAL (Preferred)	OPTIONAL (As needed)
Crisis intervention	◆		
Mental health referrals	◆		
SOCIAL SERVICES			
Social service assessment	◆		
Referrals to and follow-up with social service and other agencies for: Basic needs (e.g. food, shelter, clothing) Employment services Legal services Public assistance (e.g. AFDC, Medicaid)	◆		
Case management	◆		
On-site provision of services (e.g. food pantry)			◆
Transportation			◆

MIDDLE SCHOOL SERVICES	ESSENTIAL	OPTIONAL (Preferred)	OPTIONAL (As needed)
MEDICAL SERVICES			
Comprehensive medical and psychosocial histories	◆		
Immunizations	◆		
Comprehensive physical examinations per EPSDT guidelines	◆		
Developmental assessment	◆		
Assessment of educational, achievement, and attendance problems	◆		
Vision screening	◆		
Hearing screening	◆		
Dental assessment	◆		
Referral for dental care	◆		
Dental care		◆	
Diagnosis and treatment of minor medical problems	◆		
Diagnosis and treatment of acute medical problems	◆		
Management of chronic medical problems	◆		
Prescription of medications for minor medical problems	◆		
Prescription of medications for acute medical problems	◆		
Prescription of medications for chronic medical problems	◆		
Dispensing of medications for minor medical problems	◆		

HIGH SCHOOL SERVICES	ESSENTIAL	OPTIONAL (Preferred)	OPTIONAL (As needed)
Dispensing of medications for acute medical problems	◆		
Dispensing of medications for chronic medical problems		◆	
Laboratory testing	◆		
Referral to medical specialty services	◆		
Twenty-four hour coverage	◆		
Gynecological/Urological care	◆		
Family planning	◆		
Family planning referrals	◆		
Prescriptions for contraceptives	◆		
Dispensing of contraceptives		◆	
Referrals for contraceptive prescriptions	◆		
Condom availability		◆	
Pregnancy testing	◆		
Pregnancy testing referrals	◆		
Options counseling	◆		
Prenatal care		◆	
Prenatal care referrals	◆		
Well child care of students' children		◆	
Referrals to well child care	◆		
On-site STD treatment	◆		
Referral for STD treatment	◆		
HIV testing and counseling		◆	
Referral to HIV pre/post test counseling	◆		
On-site HIV/AIDS treatment		◆	
Referral for HIV/AIDS treatment	◆		
Case management	◆		
HEALTH EDUCATION/PROMOTION			
One-on-one patient education	◆		
Group/targeted education at SBHC Sample topics: Smoking cessation Teen parenting classes Weight reduction seminars	◆		
Family and community health education	◆		
Supplemental classroom presentations & resource support for comprehensive health education Sample topics as appropriate: STD/HIV/AIDS education	◆		

MIDDLE SCHOOL SERVICES	ESSENTIAL	OPTIONAL (Preferred)	OPTIONAL (As needed)
Pregnancy prevention			
Drug use prevention			
Intentional & unintentional injury prevention			
Chronic conditions (e.g. asthma)			
General parenting skills			
MENTAL HEALTH SERVICES			
Individual mental health assessment, treatment, and follow-up, including:	◆		
Physical/sexual abuse identification & referral	◆		
Physical/sexual abuse counseling	◆		
Substance abuse assessment	◆		
Substance abuse counseling	◆		
Substance abuse referrals	◆		
Group and family counseling	◆		
Crisis intervention	◆		
Mental health referrals	◆		
SOCIAL SERVICES			
Social service assessment	◆		
Referrals to and follow-up with social service and other agencies for:	◆		
Basic needs (e.g. food, shelter, clothing)			
Employment services			
Legal services			
Public assistance (e.g. AFDC, Medicaid)			
Case management	◆		
On-site provision of services (e.g. food pantry)			◆
Transportation			◆

ELEMENTARY SCHOOL SERVICES	ESSENTIAL	OPTIONAL (Preferred)	OPTIONAL (As needed)
MEDICAL SERVICES			
Comprehensive medical and psychosocial histories	◆		
Immunizations	◆		
Comprehensive physical examinations per EPSDT guidelines	◆		
Developmental assessment	◆		
Assessment of educational, achievement, and attendance problems	◆		
Vision screening	◆		
Hearing screening	◆		

ELEMENTARY SCHOOL SERVICES	ESSENTIAL	OPTIONAL (Preferred)	OPTIONAL (As needed)
MENTAL HEALTH SERVICES			
Individual mental health assessment, treatment, and follow-up, including:	◆		
Physical/sexual abuse identification & referral	◆		
Physical/sexual abuse counseling		◆	
Substance abuse assessment	◆		
Substance abuse counseling		◆	
Substance abuse referrals		◆	
Group and family counseling	◆		
Crisis intervention	◆		
Mental health referrals	◆		
SOCIAL SERVICES			
Social service assessment	◆		
Referrals to and follow-up with social service and other agencies for:	◆		
Basic needs (e.g. food, shelter, clothing)			
Employment services			
Legal services			
Public assistance (e.g. AFDC, Medicaid)			
Case management	◆		
On-site provision of services (e.g. food pantry)			◆
Transportation		◆	

ELEMENTARY SCHOOL SERVICES	ESSENTIAL	OPTIONAL (Preferred)	OPTIONAL (As needed)
Dental assessment	◆		
Referral for dental care	◆		
Dental care		◆	
Diagnosis and treatment of minor medical problems	◆		
Diagnosis and treatment of acute medical problems	◆		
Management of chronic problems	◆		
Prescription of medications for minor medical problems	◆		
Prescription of medications for acute medical problems	◆		
Prescription of medications for chronic medical problems	◆		
Dispensing of medications for minor medical problems	◆		
Dispensing of medications for acute medical problems	◆		
Dispensing of medications for chronic medical problems		◆	
Laboratory testing	◆		
Referral to medical specialty services	◆		
Twenty-four hour coverage	◆		
Gynecological/Urological care	◆		
On-site STD treatment	◆		
Referral for STD treatment	◆		
HIV testing and counseling	◆		
Referral to HIV pre/post test counseling	◆		
On-site HIV/AIDS treatment		◆	
Referral for HIV/AIDS treatment	◆		
Case management	◆		
HEALTH EDUCATION/PROMOTION			
One-on-one patient education	◆		
Group/targeted education at the SBHC Sample topics: Smoking cessation Teen parenting classes Weight reduction seminars	◆		
Family and community health education	◆		
Supplemental classroom presentations & resource support for comprehensive health education Sample topics as appropriate: STD/HIV/AIDS education Pregnancy prevention Drug use prevention Intentional & unintentional injury prevention Chronic conditions (e.g. asthma) General parenting skills	◆		

Appendix C: Contact Information
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Appendix D:
Profiles of Selected Sites

These profiles provide supplementary information to the Idea Book for practitioners and policy makers who recognize the importance of interactions between education and health efforts and want to create links between schools and public health-care providers. The Idea Book presents issues and strategies involved in establishing links between schools serving low-income children and community or migrant health centers—just one of many types of possible linkages in the broader field of comprehensive services—but many of the issues raised by programs linking these entities are common to a variety of links between schools and service providers. Our premise is that practitioners who want to establish school-health programs will benefit from detailed examples and advice from fellow practitioners, and that the in-depth look at issues provided by the profiles in this appendix will complement the more general overviews and the how-to guides available elsewhere.

Community or migrant health centers (C/MHCs) are health care organizations with a mandate to serve residents in underserved communities. Schools that serve low-income students and community or migrant health centers make natural partners in the effort to provide services to children in need because areas with high numbers of at-risk students often have few health or social services resources. Although schools and health centers operate in different institutional environments and provide different professional services, their efforts are mutually reinforcing. By collaborating to bring services to a shared target group, C/MHCs and schools can help one another improve health and educational outcomes for children in their communities.

We selected nine sites for this study in consultation with the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services, and with the U.S. Department of Education. Our criteria included high involvement of low-income students and variety in client demographics, urbanicity, program design and services provided, geographic location, funding sources, duration of program, and number of schools or students served. Although this was not a scientific sample, these sites were selected to cover a range of needs, issues, and strategies that are typical of many other sites.

Our sample included urban and rural sites and represented a mixture of populations. Although six sites had school-based programs, and one had a mixed school-based and school-linked design, several of the school-based sites began with simple linkages. Some sites offered comprehensive health services and links with other human services, while others provided very basic health care. The sites included newly implemented programs that faced planning dilemmas as well as mature programs in their second decade of operation that had adapted goals and services to meet changing community needs. We conducted telephone interviews with sources at all sites and visited five of the sites that illustrated typical challenges, useful strategies, or innovative solutions.

The continuum of human services offered through comprehensive initiatives can and does extend beyond the scope of sites profiled for this book. These sites are not offered as models to be replicated without considering local context; we hope that planners of new links will use the guidance offered here to develop programs that respond to local needs and connect with the resources and opportunities that each community has to offer.

Cherry Street Health Center and Henry Paideia Academy

Grand Rapids, Michigan

- **Medical and dental teams work two- to three-month stints at seven elementary schools**
- **Health center and school nurses resolved initial problems and established a better working relationship**

Overview

Rotating dental and medical teams provide school-based preventive dental services, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)[1] screenings, and acute medical services to low-income elementary students through a collaboration between the school system, a community health center, and the county's departments of health and social services.

Number of students served: 1,258 receive dental care, and 540 receive medical care annually
Grades served: K-6
Racial/ethnic breakdown: 97% African American, 2% Hispanic, 1% Anglo
Eligible for public assistance: 90%
Major sources of funding: Medicaid reimbursement, major gift from local hospital

School and Community Context

The school-health linkage, known as the Target Schools Healthcare Program, targets about one-fifth of the elementary schools in the district. Grand Rapids, a city with 250,000 residents located in western Michigan, has large Hispanic and African American populations and a growing number of Haitian immigrants. The students targeted by the health program have families that are often in crisis; one of the program's primary goals is to encourage parents to seek preventive care rather than waiting for a crisis.

The former Henry Park Elementary School, where some of the school-linked health services occur, closed in 1993 because of low student achievement scores and a generally failing education system. The school reopened in 1993-94 under the Paideia school reform system. The new Henry Paideia Academy has a Title I schoolwide program. Almost all of the students receive free or reduced-price lunches. Henry Paideia's demographics differ only slightly from those of the overall school-health program: 98 percent of the students are African American, 1 percent are Anglo, and 1 percent are Hispanic.

Major Program Features

Planning Process

Grand Rapids' superintendent of schools suggested the linkage with the community health center as a means of delivering health care to students with limited family resources. Many students had chronic ear and nose infections that were never properly treated and prevented them from attending school. Other key planners included the director of the health center, the director of the county health department, and the director of the county department of social services. During the 1991-92 school year, while several elementary schools were involved in a district-wide school improvement initiative, the

[1] Medicaid's program for children.

superintendent convened a task force with representatives from the district, the county departments of health and social services, the health center, and other community organizations to explore healthcare options for students. The committee evaluated schools with the greatest needs; criteria included students' health, facilities, and available equipment. Two elementary schools were selected for two-year pilot programs that began in December 1992. The program expanded in 1993 to two additional schools and in 1994 to a total of seven schools.

The superintendent, community health center director, and health department director signed a memorandum of understanding to develop a school-based model that would provide preventive medical services within schools. Planners formed a community-wide work group that included principals, school district program evaluation staff, and business partners to develop a plan and implementation strategy. This committee met monthly for 18 months, contacted other school-based clinics to ask for advice, collected and reviewed literature on the topic, and consulted with social workers and psychologists to identify student needs and appropriate services. There was little parent involvement at this stage. Planners also say that they initially neglected to include mental health providers on the actual planning team, an oversight they recognized during implementation when the need for mental health services became apparent.

A registered nurse from the health center began implementing the program, unassisted, in 1992. This nurse spent two and a half days per week at each of the two target schools, providing limited health screening and basic nursing services, identifying medical needs, and conducting some home visits. Students with apparent dental needs were referred to the health center's dental clinic. The nurse also talked with social workers, nutritionists, and mental health coordinators from the Department of Social Services to improve her understanding of public assistance and public health systems and to build networks for referrals.

Data collected during the first pilot year showed that the nurse spent too much time providing first aid—not a cost-effective use of her time. So the health center designated first aid the responsibility of the school nurse (who typically spends half a day per week at any individual school) or other available school staff. The medical team only sees students who otherwise would be sent home or to a doctor. The nurse and a health center physician developed a protocol for nurses to use in diagnosing strep throat, urinary tract infections, and nose and ear infections.

During the program's first year at two schools, classloads of students were bused to the clinic (one visit a year for each student); while individual students received dental exams, X-rays, and cleanings, their classmates received dental health education as a group. Although this was an effective method for making sure all eligible students received services, it was very disruptive to the school, transportation was expensive, and clinic staff found it hard to keep students interested in oral hygiene for an entire half-day. For these reasons, the program switched to mobile, school-based dental teams, serving four schools, in the fall of 1993.

During the 1993 school year, the nurse continued to provide services, alternating morning and afternoon shifts at each of the four schools and spending the fifth day at the health center to conduct follow-up calls. However, acute care[2] needs were not sufficient to keep the on-site nurse busy each day. Planners added a pager system so the nurse could be more flexible and respond to acute care needs only when they arose, rather than remaining idle while waiting

[2]Care of illnesses in which the symptoms or discomfort develops very quickly—over only a few hours or days. For other health or education terms that may be unfamiliar, please refer to the glossary in Appendix A.

for them to happen. Planners made other changes after realizing that much of the success of the dental component came from the fact that it emphasized screening, preventive care, and early intervention—approaches that the medical program lacked. The medical team expanded in 1994 to include a medical assistant. The program also added three more schools, another nurse, two medical assistants, and EPSDT screenings, which have become the major component of the program. The two medical teams now rotate among schools, staying at each long enough to complete EPSDT screenings for all eligible children.

Program Design

The program operates from 8:30 a.m. to 4:30 p.m., although medical staff often stay until 5:30 p.m. for parent conferences or to see additional students. Medical services include EPSDT screenings for all students with signed parental consent forms, follow-up services, limited case management, acute care, and home visits when needed. Dental services include check-ups, X-rays, cleaning, and application of fluoride and dental sealants; restorations are referred to the health center or to other dentists in the area, although very few are willing to accept Medicaid clients. Students also receive a free toothbrush, dental floss, and instruction in the basics of good oral hygiene during each visit. The most common acute care needs include upper respiratory infections, injuries, rashes, infections, wounds, and pain. The most common dental problems are neglect and nutritional deficiencies.

The teams enter student records into a portable computer and later transfer them to the clinic's main system. After rotating to a new school, the teams try to remain in contact with students who need follow-up services.

Confidentiality. The medical team insists that parents or guardians be present during EPSDT examinations, which are followed immediately by parent conferences to discuss any abnormal findings. Nurses will confirm whether or not a student has consulted with a doctor and will answer any questions parents have. When clinic staff refer a student to an outside physician, the program avoids confidentiality issues by making follow-up calls to the student's parent rather than the physician—so clinic staff do not receive information directly from outside care providers.

Parental consent. Before receiving medical or dental services, students must return a signed parental consent form. All students who return signed consent forms are considered eligible for services. Typically, between 80 and 90 percent of the students return signed consent forms. All children who return dental consent forms receive services without a parent's presence, but parents must accompany their children to school for EPSDT screenings. Parents need not be present for acute care. The program has had some difficulty ensuring that parents follow through on the requirement for attendance at EPSDT screenings.

Referrals. Because the medical teams consist of only a nurse and a medical assistant, the program does not make referrals to specialists. Students are referred to their family doctors or to a primary care physician at the health center. Staff refer between 60 and 65 percent of the students to other health care providers for further treatment, usually for dental, vision or hearing problems, anemia, scoliosis, or other medical conditions. Some students are referred to a single provider while others may be referred to three different providers because they have more diverse needs or because clinic staff want to spread the demand among providers.

Clinic staff make follow-up calls to families to ensure that they contact the recommended referral. Clinic staff gauge their success by the number of referrals made, number in progress, number resolved, and whether the resolution was

good or poor. (A good resolution means that the family followed through on making and keeping an appointment. A poor resolution is when, after repeated attempts to get the family to follow through, no appointment is made.)

Integration and coordination with academic program. There is very little integration between the health services and school curriculum or staff; the health center focuses its efforts on providing individual health education and medical services, not classroom health education. After hosting the dental team for several months, one principal commented, "We did not even know they were here." This was intended as a positive comment on how smoothly the dental team operated, but it also shows that interaction with school staff is limited. The program does not include health education (except for basic dental hygiene), which the health center views as the responsibility of teachers, school nurses, and other support staff provided to teach the Michigan health education curriculum.

Organizational/Management Structure

An oversight committee—including school principals, an evaluator, the clinic nurse/manager coordinator, business partners, and representatives from the county departments of health and social services—meets quarterly to discuss programmatic problems, proposals for improving or expanding the program, and strategies for obtaining resources. The committee is chaired by the director of Cherry Street Health Services, whose time is donated by her fulltime employer, a local hospital. During planning and the early stages of implementation, this group met monthly; planners switched to a quarterly schedule when meetings became routine and attendance dropped.

The daily and weekly aspects of the program are coordinated by a nurse on one of the medical teams. She works closely with the health center's medical director, the dentist in charge of school services, and the school principals. A physician at the health center reviews the charts every week, provides protocols for treatments, and serves as a consultant for nurses. The physician is available at all times by beeper. The on-site dental teams include a dentist who conducts exams and takes X-rays, and a dental hygienist and assistant who clean teeth and apply fluoride and sealants. The teams meet monthly to evaluate program operations, discuss barriers, and consider solutions.

Staffing

Each medical team is staffed with one registered nurse and one medical assistant. The nurses must be licensed by the state and have experience with ambulatory, out-patient care; all have a great deal of experience in family practice and pediatric medicine. The medical assistants have graduated from certified programs or have equivalent experience. The three dental teams consist of a dentist, dental hygienist, and dental assistant. The dentist and dental assistant conduct exams and X-rays. The hygienist and dental assistant provide cleaning and education. Staffing the program has been relatively easy because, with the exception of the dentist, all positions follow the academic calendar—so staff have the summer off. This feature has attracted many staff who are also mothers of school-age children.

The Cherry Street physician supervises the medical teams, reviews all patient charts, and authorizes all medical treatment protocols. Medical staff report to the nurse who heads both medical teams. The dental teams are headed by the dentist on each team, one of whom acts as the overall coordinator.

Funding and Reimbursement

The health center is a federally qualified health center and therefore can claim reasonable costs for serving the area's Medicaid and Medicare patients (about 70 percent of the population). The center receives reimbursements for

70 percent of its costs. In early 1995, the state's eligibility requirement for Medicaid was raised from 100 percent to 185 percent of the poverty level. This will increase the percentage of costs that the health center can claim, because more students will be covered by Medicaid.

Medicaid reimbursements cover most of the school-health project's budget (about $325,000 a year). About 70 percent of the students receiving medical services are eligible for Medicaid, 5 percent have private insurance, and 25 percent are uninsured. For dental services the percentages are similar, although a higher percentage of students are uninsured. The cost of serving uninsured students is covered by a $100,000 gift from a local hospital ($84,000 for operating expenses and $16,000 for the purchase of portable dental equipment). 1994-95 was the first year of the hospital's contribution, but planners expect that the gift will be renewed. The schools provide space for the health programs.

The program's medical services cost more than initially expected, primarily because of parents' missed appointments. To bring costs down, staff have begun to over-schedule appointments to compensate for no-shows and have begun to offer grocery coupons and other incentives to encourage patients to keep appointments. However, the cramped quarters in which the program operates make it hard to accommodate waiting parents. Dental costs are lower than expected—in 1993, about $45 or $50 per student visit. Adding a dental assistant to work with the hygienist has increased productivity significantly—staff had more than 600 dental encounters in December and January of 1995—and dental costs are likely to drop to or below $40 per visit.

Family and Community Involvement

The school-based clinic does not focus on services to families, with the exception of an immunization clinic at which students' siblings also received services. Although families appreciate the medical services the linkage provides, medical staff say that many parents are unable to participate in their children's school lives as much as they would like because of work commitments, personal problems, or lack of parenting skills. One principal makes home visits to parents who do not attend school meetings and, with the support of the superintendent and school board, requires parents or guardians to attend a teacher-parent conference.

Lack of parent involvement has been the biggest problem facing the medical teams. Parent compliance with scheduled appointments in some schools is below 50 percent. Although health center staff believe they could legally complete EPSDT screenings for students with signed consent forms even if their parents are unwilling or unable to attend, that is not a step staff want to take because they fear that without the parent attendance requirement, many of the parents who do keep their appointments would be less inclined to attend. Medical staff believe that face-to-face consultations with parents after the screenings helps parents understand and commit to proper health care for their children. The program coordinator is developing incentives for parents to keep their appointments, including meal coupons from restaurants and vouchers for groceries.

The community supports the school clinics. Because Grand Rapids is politically conservative, the program's focus on elementary schools—rather than middle or high schools, where family planning might be an issue—has helped avoid controversy. The health center recently received a Healthy Schools/Healthy Community grant to develop a more comprehensive, permanent school-based clinic at a school that serves grades K-8, which may be more controversial.

Implementation Issues, Barriers, and Solutions

Turf issues among private physicians. Some private practitioners in the community do not like having health center nurses assess illnesses, even for minor health problems. Other health care providers simply want to work with the nurses before giving approval for these health assessments. Some physicians oppose school-based health care because they believe that school-health linkages further fragment the health care system. In response to these complaints, clinic staff emphasize to students and families that the screenings are only preliminary and that patients must follow up with visits to doctors. Clinic nurses also present themselves as outreach workers for the community doctors who can reach those patients who are unwilling or unable to visit doctors' offices.

Issues among school nurses. When the program began, school nurses filed a grievance against the public school system, saying that the district had subcontracted services that could be provided by the school nurses. School nurses were concerned that if the cash-strapped schools could get community clinics to pay for health services, the nurses' role would be phased out. They were further concerned about the fact that medical staff covered by the health center's liability insurance could provide more comprehensive services than school nurses. In 1993, an arbitration judge ruled that the health center nurses provided different, nonduplicated services. Since then, the Cherry Street nurses and school nurses have tried to improve their relationship by working on projects together, such as a joint school health fair. School nurses also have formed a group to pilot some protocols and a supervision program that would allow school nurses to assume greater responsibility in providing health care.

Coordination with managed care and Medicaid. Among the biggest issues facing the program is the state's recent move to managed care. All Medicaid-eligible individuals must have, or are assigned, a designated provider and medical "home," a medical practice that is the source of all services and/or referrals. Many Medicaid clients select the health center host agency as a medical home, but nurses in the school clinics cannot receive reimbursement for EPSDT screenings for students who are enrolled with other managed-care providers who have not authorized the program to provide services. So far, two hospital clinics have granted authorization and two have refused.

Clinic staff record students' managed-care providers on the signed consent form that students file every school year. Staff notify parents that they cannot provide services if the student is enrolled with a provider who does not grant authorization. If a patient returns a consent form despite being registered with another provider, the program coordinator calls that provider, explains the EPSDT screening, and asks for authorization. The reaction from providers has been mixed. Without authorization, clinic staff have to decide whether the student is likely to get the services from his or her registered physician. If not, they often conduct the screening with the understanding that they will not be able to claim reimbursement. Health center sources are concerned that as the managed-care environment begins to attract health maintenance organizations (HMOs), the health center's reimbursement rate will be threatened and the program may not be able to compete effectively with the HMOs' aggressive marketing tactics and budgets.

Accountability and Assessment

Under the agreement between the school system and health center, the schools bear responsibility for evaluating the program. The district conducts an annual survey of students,

parents, teachers, and principals and collects qualitative and quantitative information from the program coordinator, the Target Schools Healthcare Task Force, and the director of the health center. The school-health program's second-year evaluation identified the following objectives for 1993-94: (1) Ensure that all children in designated schools are provided access to and assistance in receiving EPSDT or alternate screening procedures, (2) broaden the program to cover a minimum of six schools and develop linkages with other providers, (3) maximize Medicaid and other reimbursements by using school nurses and volunteers for non-reimbursable services, and (4) enhance use of the program by obtaining feedback from parents and by coordinating with school nurses.

Impacts

This program has done little to track impacts. However, the new Healthy Schools grant carries rigorous expectations for documenting impact, including a software package for tracking patients and outcomes. As staff learn to monitor outcomes at the demonstration site, they expect to apply the same techniques to the other school programs. The program serves such a needy population that the staff feel that almost any service makes a difference in the students' lives. Principals say they see happier, healthier children just as a result of the attention given to them by the clinic staff. Dental staff began to examine students on a broad basis in 1992, and staff expect to see decreases in dental problems as a result.

Clinica Adelante and the Queen Creek School District

Queen Creek, Arizona

- **School nurse and clinic staff work closely to provide primary care services to children and families**
- **School linkages are viewed as an essential method of bringing families with few healthcare alternatives into the clinic**
- **Physical exams for school sports provide an access point for health care in the schools**

Overview

This program provides school-linked health services to students and their families in a small, rural community through a satellite community and migrant health clinic.

Number of students served: Not documented
Grades served: preK-12
Racial/ethnic breakdown of clinic users: 70% Hispanic, 25% Anglo, 5% other
Children living in poverty: 34%
Major sources of funding: Federal community and migrant health grants, local foundation

School and Community Context

Queen Creek is an agricultural community of 2,600 residents located one hour east of Phoenix. Queen Creek has a majority Anglo population, a strong Mormon community, and a large Hispanic minority including many migrant farm workers from Mexico. Thirty-four percent of children below age 18 live in families whose incomes are below the federal poverty level. Major health needs in the area are for basic medical services, dental care, mental health services, immunizations, nutrition education, and pharmacy services.

Queen Creek only recently incorporated as a town, and elected its first mayor and council in 1992. The freeway from Phoenix to the eastern portions of the valley was completed in 1994, and developers are building housing and shopping centers nearby. Before Clinica Adelante opened, the nearest doctor's office was 25 miles away; there is no public transportation in the area, and few migrant farm workers have private transportation.

As part of a cost-cutting policy, the state requires Medicaid recipients to enroll in a managed care plan. The state provides up-front, lump sum Medicaid reimbursements to health maintenance organizations (HMOs), and HMOs may in turn contract with other providers for services. Clinica Adelante serves many non-citizens who do not qualify for state Medicaid and residents who cannot afford private insurance.

Social services have only recently become available in Queen Creek, and they remain limited. A family resource center across the street from the high school and middle school houses an intake worker from the state's welfare department, who visits once a week to enroll eligible families in AFDC, food stamps, and Medicaid. The town recently received a federal community development block

grant to build a teen center that will offer recreation, nutrition, counseling, and other youth programs.

The school district serves approximately 1,200 students in three schools; the high school and middle school share a campus. The school district's offices are located on the high school/middle school campus, and interaction between district and school staff is regular and informal. In the early 1990s the district hired a new superintendent and elementary school principal, and there has been some turnover among school board members, but the principals of the high school and middle school have been in place since the school-health program began.

Major Program Features

Clinica Adelante is located in a strip mall across the street from the high school/middle school campus. The property, which also houses some school administration offices, is owned by the school district. The clinic's school-linked program provides services through informal arrangements with the school district; because of the informality, participating agencies are not sure how many students receive services. In the first six months of 1994, the clinic documented 1,600 health contacts, of which 120 were to children between the ages of 10 and 18. There are no data for young children or for the proportion of children or families served as a result of school referrals and other linkages.

Planning Process

This program began in 1985 as a mobile health van operated by the main clinic to serve migrant farmworkers in outlying areas of the Phoenix valley. The van visited Queen Creek weekly to provide immunizations, health screening, and other primary health services. Hours were flexible and the van stayed as long as there were people waiting for services—often into the evening. Recognizing the need for more regular health services in these communities, Clinica Adelante decided in 1991 to replace the van with several full-time satellite clinics. The transition included establishing extended hours one day per week and staffing the satellites adequately to meet requirements for receiving a state license and qualifying for Medicaid reimbursements.

At the same time, the school district developed a comprehensive educational plan that recognized that the toughest problem in education is the social, economic, and personal problems of the students that prevent them from learning. The plan's goal was to explore ways to integrate the community's resources to support the education of all students. To address this goal, the high school principal—who had directed a prevention program and family center in a nearby community—the district superintendent, and the school board established a family resource center in Queen Creek with the goals of reestablishing linkages between youths, families, schools, and the community. State and local agencies station staff at the center to improve access to social services, although the center's development has been hindered by staff turnover and funding issues. The school board supports the center as long as the school itself does not fund or provide services directly.

In addition, the principal asked Clinica Adelante to expand its services to the community to support the comprehensive educational plan. The school district had hoped to design school-based health services, but community resistance to a direct role for schools made this impossible. However, once the school district, town council, and health center agreed to establish the satellite clinic at the strip mall, the process of obtaining a state license, hiring staff, and setting up the clinic moved quickly (approximately five months). Clinica Adelante/Queen Creek opened in late 1992. The only formal arrangement between the school district and the clinic is the lease agreement for the clinic's offices.

Program Design

By maintaining close, informal links with the schools, the clinic expects to make students more comfortable with health staff and more inclined to use the clinic. Services include: (1) School and sports physical exams, including vision and hearing screenings, at a flat rate of $10 for any school-aged child, regardless of family income. This has been a major strategy for getting children and parents into the clinic and for providing EPSDT screenings; (2) immunizations, especially for migrant children who arrive during the school year; (3) prenatal care, services provided by the federal Women, Infants, and Children (WIC) program, and home visits for pregnant teens, in partnership with a community volunteer; (4) substance abuse counseling for student athletes from the middle and high schools who fail mandatory drug tests; (5) home visits with—or at the request of—the school nurse to students' families to provide information about basic health, nutrition, hygiene, and available health services; (6) health education, including guest lectures at the high school and middle school and for parents as part of the Title I preschool program. Clinic staff helped the school district implement an AIDS education program by providing lectures for Spanish-speaking students.

The selection of these services developed over time according to the needs of the schools and the capacity of clinic staff; it is not based on a formal plan. The school district nurse, the high school principal, and the clinic's nurse practitioner work particularly closely. The school nurse makes most of the referrals; school staff usually refer first to her and allow her to make referrals to the clinic. This arrangement facilitates clear lines of communication between the schools and the clinic. The school nurse usually refers children to the clinic and follows up to ensure that they get there—but whether services such as immunizations are provided solely by the school nurse on school grounds, by clinic staff on school grounds, or at the clinic depends on the child's needs and the capacity of the school nurse.

Parental consent. Parental consent and confidentiality procedures maintain the separation between the clinic and the schools. Parents must accompany their children or provide written consent when children visit the clinic. The clinic's nurse practitioner strongly encourages students to communicate with the school staff who refer them but does not share any case-related information with the schools or other institutions unless there is a duty to report (e.g., evidence of child abuse or neglect).

Organizational/Management Structure

The organizational structure is informal, based on physical proximity and relationships among individuals in the school system and at the clinic. Communication is *ad hoc*; there have been few regular congregations of school and clinic staff to develop or refine a common vision or strategic plan.

The clinic and the school district are financed entirely separately and have separate governing boards. The school board does not have authority over clinic activities, although it can establish guidelines for health education and services provided directly on school grounds. The board members and administrators of Clinica Adelante have not made any formal arrangements with the school district other than to lease the clinic's office space. The institutional separation is based on a strong community belief that schools should provide only education, and health and welfare agencies should provide social and health services. Residents and parents are particularly concerned that schools avoid issues related to sexuality, although the school can address these issues for some students through referrals to the clinic. Generally, the schools maintain a "don't ask, don't tell" policy toward these referrals. Lacking formal organizational ties, the school-health linkages function because of individual relationships and a shared commitment among school and clinic staff to the healthy development and learning readiness of children.

Staffing

The clinic's primary medical staff person is a nurse practitioner, who is also the site-based manager. She provides all diagnoses and is the main contact for the schools. She is assisted by a licensed practical nurse (LPN) who screens patients and provides support to the nurse practitioner. A community health nurse, whose primary responsibility is outreach, provides home visits and health education and maintains relationships with schools and other organizations. The WIC program provides nutrition education and food vouchers. Lay health workers, hired by a state-funded prenatal education and advocacy program called Health Start, make home visits to pregnant women and families with young children. The clinic also works closely with the Arizona State University school of nursing and is a regular site for nursing interns. A student psychiatric nurse practitioner staffs the clinic once a week and another student nurse practitioner spends one day a week working with the clinic's nurse practitioner.

A physician at Clinica Adelante's main office supervises medical staff; this person is on site once a week and available by phone at all times. While on site, he reviews charts, meets with staff, and sees patients who require additional medical care. In addition, Clinica Adelante staff from all facilities attend monthly systemwide meetings. After a meeting of the entire staff, practitioners meet in small peer groups to exchange ideas.

Several school staff work particularly closely with the clinic. The school nurse, who serves all three schools in the district, regularly turns to the clinic for assistance and also helps monitor the health of clinic patients. She approached clinic staff soon after she was hired to establish a relationship; recently, she arranged to maintain her own supply of vaccines and administer them at the schools to relieve the clinic of some of its immunization workload. The high school principal, who is also the director of the family resource center, coordinates with clinic staff and makes many referrals to the clinic. The high school counselor coordinates counseling services with the clinic's psychiatric nurse practitioner intern.

The high school principal and counselor established and trained teams of school staff and teachers who help identify and address the needs of students at risk of school failure. Participating staff receive three days of training that focuses on (1) general knowledge about risk factors, (2) approaching students about sensitive issues, (3) making referrals, and (4) facilitating counseling sessions. These staff then intervene throughout the school to help students with personal and family problems that affect school attendance and performance.

Funding and Reimbursement

Until recently, the health center did not maintain separate budgets for its various facilities, so an exact accounting of the clinic's operating costs is not available. The director estimates that it costs roughly $150,000 to operate the clinic, most of which covers staff salaries. Funds for the school-linked clinic services come from the community and migrant health center and are composed of federal migrant and community health grants and a grant from a local foundation. The community outreach nurse is funded through the state Health Start money. The schools are not allowed to dedicate education funds to the linkage because of the community belief that academic and social service roles should be separate.

Self-sufficiency is a major concern for the clinic. Staff work continually to increase the clinic's Medicaid and sliding-scale fee caseloads and to reduce the reliance on grant funding. As long as the clinic serves non-citizens, however, it will have to obtain private funding and funds set aside for migrants.

Family and Community Involvement

The school-health linkage brings families to the clinic for services; word of mouth has been a very effective means of advertising. School staff say it has not been hard to get students to go to the clinic in part because parents are grateful to find out about the service and because the clinic will provide services to the student's entire family.

The community is just beginning to be directly involved in the school-health linkage. To avoid controversy, the schools and clinic deliberately maintained a low profile about their relationship—and, because of the clinic's Spanish name and its past as a mobile clinic for migrant workers, many community members view the clinic as a place primarily for migrant workers. Hispanics continue to comprise the bulk of client visits. In the wake of recent gang activity, and with the support of the school board and town council, the Kiwanis Club has agreed to partially support the expansion of the clinic and its youth services; a local architect and contractor donated time and materials. The new space will include five exam rooms, a lab, and a waiting area. The current space will then house WIC staff and additional mental health services.

Cultural Inclusiveness

The schools rely on the clinic to help them meet the needs of migrant and Hispanic students and to provide translation for the school nurse and other school staff. All of the clinic staff are fluent in Spanish, and several are Hispanic. The psychiatric nurse practitioner student who provides counseling was a migrant farm worker as a child. School staff, including the principals of the high school and middle school, the school nurse, and the school counselor, are all Anglo and do not speak Spanish. Clinica Adelante is regarded by area managed-care organizations as a "culturally appropriate, sensitive provider" that can reach non-Anglo populations, according to the program director. Managed-care providers that receive Medicaid funds are audited for EPSDT and immunization rates in their service areas, and contract with clinics like Adelante to reach rural and minority children.

Implementation Issues, Barriers, and Solutions

Community's view of the appropriate role of schools. In addition to making the health services school-linked rather than school-based, the program addressed community concerns by (1) maintaining a low profile and separate institutional roles for the school and clinic, and (2) providing services to meet needs recognized by the community rather than forcing a plan on the community. The main disadvantage to these strategies is the possibility that the program will not reach many who need services because the program is separate from the school and not widely publicized.

Isolated working environment for medical practitioners. Staffing a satellite clinic, whether on or near school grounds, can isolate health care practitioners accustomed to supervision and interaction with peers. Practice in a rural, basic health care setting also challenges staff who enjoy broader exposure and experience. The main clinic, located more than an hour away, must balance adequate support and monitoring with allowing freedom to tailor services and strategies to community needs. The nurse practitioner at the satellite clinic assumes certain administrative functions by default and must juggle this role with a busy medical practice. For clinic staff, the transition from mobile van to full-time clinic required a more structured practice and knowledge and use of formal reimbursement policies.

To mitigate staff problems in this setting, the program director screens job candidates carefully for the ability and desire to be flexible, adaptive, politically astute, and self-motivated. The nurse practitioner spends one day a month at the main health center to maintain her skills. The staff's sense of separation from the main health center lingers, however, and are likely to grow as the satellites receive pressure to become self-supporting.

Operating in a managed-care environment. The area's health maintenance organizations have been willing to contract with Clinica

Adelante for care they cannot provide. State audits of immunization and EPSDT rates provide incentives for HMOs to serve at least these basic needs through the school-linked clinic. Clinica Adelante's major challenge in working with HMOs has been the paperwork required for reimbursement, which differs with each HMO. Occasionally, an HMO refuses to recognize the nurse practitioner as a qualified provider, in which case the clinic must bill under the supervising physician's name.

Lack of transportation. Transportation, public or private, remains a problem for residents of this rural community. Clinica Adelante is easily accessible by foot from the schools, but children needing additional services still must travel 25 to 30 miles. Clinic staff occasionally provide transportation but it is too time-consuming to do so regularly.

Meeting state licensing requirements. State licensing requirements for health service organizations include maintaining a certain staff mix and establishing and following protocols for service delivery and supervision. This provided more of a challenge while operating the mobile van than for a full-time clinic. However, the program director remains frustrated with the state restrictions, which have discouraged efforts to implement innovative service delivery strategies.

Accountability and Assessment

Although there is no formal system for documenting or evaluating the school-linked services at Clinica Adelante/Queen Creek, nursing students from Arizona State University conduct community health needs assessments as part of their coursework, the high school administered a teen survey to ascertain students' health concerns, and a Youth Advisory Council has interviewed community members about health topics. The clinic recently began collecting data on children served, but because funding is not targeted explicitly for the provision of school-linked services, data documenting this activity are not in demand. Assessment is driven by its ability to meet overall service delivery and financial goals.

Impacts

Evidence of the strength of the school linkage is largely anecdotal—as in the following story:

> *A student athlete went to the clinic for his required sports physical. The nurse practitioner concluded from tests that he was using drugs. The student admitted using drugs, and the nurse practitioner suggested that he talk with the high school principal about getting counseling at the clinic in exchange for the chance to keep playing football. The principal was supportive and monitored the student's weekly attendance at the clinic for counseling. The student is "clean," still in school—and playing football.*

Fort Pierce Family Service Center, Fort Pierce Elementary School

Fort Pierce, Florida

- **School-based health center serves children, families, and the community**
- **Comprehensive family service center establishes close and effective links between medical and mental health services**
- **Immunizations and physical exams provided by the health center means schools do not have to block students' enrollment for health reasons**

Overview

Although the Fort Pierce Family Service Center is located on school grounds and the school serves as an important link between the services and the community, this program focuses on serving entire families, and planners consider it more school-linked than school-based. One of two such centers operated by a private non-profit company under an agreement with the county school board, the family center targets the medical needs of children and youth from birth through age 18. Since 1993, the center has served more than 1,000 clients, most of whom live in poverty and have no other source of health care.

Number of students served: More than 300 students (40%) use services
Grades served: PreK-5
Racial/ethnic breakdown: 51% Anglo, 38% African American, 11% Hispanic or Haitian
Eligible for public assistance: 77% of students eligible for free/reduced-price lunch
Major sources of funding: Federal Public Education Capital Outlay (PECO) funding, state Full Service Schools grant, special taxing district for children's services

School and Community Context

Fort Pierce (pop. 36,000) is located on the Atlantic coast of Florida, 100 miles north of Miami. The area's immigrant population has increased recently. In Fort Pierce, 49 percent of the residents are Anglo, 45 percent are African American, and 6 percent are Hispanic or other. Approximately 35 percent of the adult population is illiterate. Approximately 30 percent of school-aged children do not have health insurance. The school district is the largest employer in the county; other major employers include a regional medical center and various agricultural and retail companies. The county's unemployment rate averaged 13.2 percent in 1993.

Fort Pierce's school district is unique in Florida because it has controlled choice zoning, a policy that responds to court-ordered desegregation. Controlled choice divides the county into three zones; within each zone, parents may choose among a prescribed list of schools. Based on the parents' preferences and the need for racial balance, the school district assigns children to schools.[3] As a result of controlled choice zoning, most children

[3] The school district recently approved "walk zones" that will allow children to choose a school within walking distance of their home, even if the school is not among those from which they would normally choose.

who attend Fort Pierce Elementary School do not live in the immediate community; some live up to 26 miles from their school. This lack of connection with the community made it difficult for the school to initiate relationships with community-based organizations.

Fort Pierce Elementary School has 778 students and is in its first year of a Title I schoolwide program. The Family Service Center, operated by Florida Community Health Centers, Inc. (FCHC), is housed in a large trailer on school property, some distance from the school. The trailer, which is owned by the school district, houses a children's center and WIC staff in addition to the Family Service Center. The agencies that provide services at the center were all operating before the Family Service Center opened—but without the formal link to the school district, public awareness and access to the services were limited. The school district's ability to provide resources, start-up expenses, and new clients gave it leverage with the agencies to encourage the development of the health program.

Major Program Features

The Fort Pierce Family Service Center is one of two centers operated by FCHC (the other is at Windmill Point Elementary School). The centers offer one-stop shopping that links health care, social services, and education. Agencies that operate out of the centers include FCHC (medical services); New Horizons Children's Center (mental health services); and the federal Women, Infants, and Children (WIC) assistance program. The Fort Pierce site also offers Even Start and adult education supported by a local community college and a federal grant to the school district.

During 1993-94, the Fort Pierce health center treated 971 people, of whom 55 percent were under 5 years old and 27 percent were between 5 and 10 years old. The racial distribution of clients at both centers is 52 percent Anglo, 28 percent African American, 12 percent Hispanic, and 8 percent Haitian. Eleven percent of the clients are migrants. Statistics on the minority population served at the Fort Pierce site are not available but the figure is probably higher, because the community has a higher minority population. The most common medical services or diagnoses are routine infant/child health checks, acute upper respiratory infection, DPT and polio vaccinations, and noninfectious gastroenteritis/colitis. The number of patient contacts per month grew steadily during the center's first year, from an average of 367 during Fiscal Year 1993 (October through March) to an average of 511 during the first five months of 1994.

Planning Process

This project began as an effort to place nurse practitioners in the schools. The impetus came from the district's director of student services, who used data on high poverty levels, poor access to health care, limited public transportation, and high levels of health and education risk among children to gain community support. Together, the director of student services and various community groups convinced school staff and administrators to pursue the idea. When budget cuts in the county public health department made the original plan impossible, the planners turned to FCHC for support.

FCHC saw the connection with schools as a way to gain space for expanded services and a link with the community. A formal agreement between FCHC and the school board put the school board in charge of providing the site, facility, and equipment for the health center. FCHC provided staff, funding, and oversight of the center's daily operations. FCHC's medical director, the district's director of school services, principals, and the site coordinator jointly developed the program over the course of one year.

Planners faced several political obstacles. First, they did not want the clinic to be perceived as stealing clients from established health care providers. To prevent this, they publicized the fact that the county has a shortage of pediatricians, encouraged the concept of using primary care physicians, and emphasized that no one would be obligated to use the school health center. Planners also anticipated problems surrounding family planning services, although the school district recognized the need to increase accessibility to these services. Planners agreed that the centers would not distribute family planning literature and birth control—an arrangement that almost derailed the project because of opposition by the medical staff. Today, family planning remains a very low-key component of the project and clinic staff do not distribute birth control. Students with family planning needs are referred to the main FCHC, off the school site.

Logistical issues dominated the planning stage. School building regulations required that the facility have separate bathrooms for male and female students and for staff. Clinic staff saw this as a waste of limited space and a constraint on the program's ability to generate revenue because it would reduce the number of patients who could be served. Responsibility for cleaning the facility presented another issue; because the center is in a school building, FCHC thought the school should provide janitorial services, but the school refused. Planners compromised: The school repairs the building, while FCHC handles daily cleaning.

Program Design

The centers provide comprehensive pediatric health services (lab work, immunizations, vision and hearing screening, physicals, gynecological services, and HIV care) and acute care Monday, Wednesday, Thursday, and Friday from 8 a.m. to 5 p.m., and Tuesdays from 10 a.m. to 7 p.m. A staff member is always on call.
The Fort Pierce center's ability to provide immunizations and physical exams for new students, and mental health services for all students, has been most immediately helpful to the school. In the past, many children were temporarily prevented from attending school because they had not met immunization requirements; since the center opened, no students have been kept out of school for lack of immunizations.

Only a small percentage of patients are referred by Fort Pierce elementary, although many are referred by other schools in the district. Most users are not even of school age; they are identified through community outreach and referrals from other social service agencies. Outreach includes inviting community groups and service agencies to tour the family center, offering staff as speakers for community groups, disseminating a district-wide newsletter, inserting articles into school newsletters, sending flyers home with students, and promoting services on the district's cable television channel.

Coordination and cooperation among medical, mental health, and school staffs are key features of the Family Service Center; because most student referrals are rooted in behavioral problems, medical and mental health staffs must also work well together. Program staff say that successful collaboration and coordination is more a result of hard work and responsive personalities of the people involved than of any structural mechanism.

Confidentiality. The high level of collaboration raises confidentiality issues: Each service provider wants to know what services their client has received from other providers. The service center solves this problem by having families sign an interagency shared consent form, modeled after a standard medical consent form. Members of the medical, mental health, and school staffs also meet weekly to discuss patients and the mental health and medical staffs hold parent conferences when appropriate.

Referrals. The family centers make many referrals to outside providers, although percentages for specific needs were not available. Sources reported some problems with referring patients who have no insurance or who need specialists who are not located in the area. Some patients must wait for referral services while family center staff arrange Medicaid registration, and it can be hard to convince some specialists to take Medicaid patients. Family center staff are persistent in asking or pushing other providers to take these patients. Lack of transportation is also a barrier; the county does not have public transportation and often referrals are made to providers outside of the county. The community has a shuttle van, but families often must wait for hours to get to or leave an appointment.

Organizational/Management Structure

A coordinator hired by the school district serves as liaison between the school and agencies at the family center. The coordinator interacts regularly with the principal, guidance counselor, and teachers to help them understand the services available and identify children in need of health and/or social services. The coordinator also helps the service providers coordinate efforts across agencies and referrals to outside providers or agencies. Sources at the agencies and school said the coordinator was crucial to program success because she opened lines of communication between schools and agencies where they did not exist before. As the program grows and more schools use the resource, however, it is harder for the coordinator to personally facilitate communication.

Issues beyond day-to-day coordination and management are addressed jointly by the school board, FCHC officials, center staff, school administrators, and the site coordinator. An oversight committee meets quarterly to direct development and oversee budgets. Its members include principals; school board members; business leaders; and representatives of social service agencies, the community college, and the public health unit.

Staffing

The school district contracts with FCHC to provide services but not specific positions or staffing arrangements. FCHC staffs the centers based on what the center feels it needs to provide services cost-effectively. The Fort Pierce family center is staffed by a full-time pediatrician, a nurse, a medical assistant, and two administrative office workers. Most of the health services are provided by the pediatrician. A mental health service contractor is expected to provide two full-time counselors, and the school district provides a site coordinator. A WIC staff person visits the site two days a week, although recent budget cuts have reduced the frequency of the WIC visits.

The primary staffing issue at Fort Pierce has been high turnover rates among mental health staff. In 1994-95, the center operated for much of the school year without one of its two counselors. The county school district has only one school nurse, who circulates among the schools to provide basic health services. Her role has not changed much since the clinic arrived—she is still overworked—but she now can refer students to the two Family Service Centers. Instead of being threatened by the service centers' role, the district nurse finds that they generate more work for her by referring students for screening, prescribing medications, and recommending home visits.

Funding and Reimbursement

The school district receives a grant from the Florida Full Service Schools program (approximately $108,000 in 1993-94). This grant covers the costs of the full-time program coordinator, a part-time paraprofessional, and administrative and operating expenses. Several sources said the funds provided by the state grant were crucial to the development of this project.

Because the school district, FCHC, and other providers maintain separate financial records, it is hard to create a consolidated budget for the family service center. Based on FCHC's

income summary of April through August, 1994, the major expense is for salaries, wages, and benefits (about 65 percent of total expenses). The average cost per patient contact is $58. FCHC writes off an average of 6 percent of total expenses per month as bad debt. The program charges for all services. Uninsured patients pay sliding fees, with a minimum payment of $12. The county school district contracts with FCHC to provide the medical and billing services. In early 1994 at the Fort Pierce center, 49 percent of the students were covered by Medicaid, 48 percent paid out of pocket, and 3 percent were covered by insurance. During the same period, the school-based centers had a net revenue of $334,024 and expenses of $280,123, for a net profit of $53,901.

From the school's point of view, the center has no negative effect on its budget; in fact, the principal said the school has benefitted from having access to office equipment in the site coordinator's office, such as a fax machine—an item the school did not have.

Coordination with health insurance. Healthy Kids, a nonprofit program established in 1990 to provide low-cost health insurance to school-aged children in Florida, is a major component of the family service centers. Healthy Kids has two goals: to create comprehensive insurance coverage for school children and to help provide preventative health care for children. Fort Pierce's county is a pilot site for the program, and as of October 1994, all children in the county between age 5 and 19 who are enrolled in grades K-12 and have no private or government-sponsored health insurance are eligible for this coverage. Premiums range from $5.00 to $43.00 per month, depending on family income. The family service center receives several inquiries about the program every day; so far, staff have signed up more than 1,000 students who previously lacked health insurance, most of whom had not been participating in the health care system. Healthy Kids receives funding from the state and from the county Children's Services Council—a special taxing district authorized to raise money and distribute grants for children's services.

Family and Community Involvement

In almost all cases, a parent must accompany a child to the clinic for medical services, although the principal can authorize services in emergencies. The center staff would like to develop a release form that would allow students to receive services without having a parent present. This type of release is now used with a few patients who need regular services. But because FCHC charges for its services, handles its own billing, and must be able to confirm financial responsibility for all services—and because FCHC must cover its operating costs—having parents accompany the children helps the clinic collect more revenue. FCHC already absorbs many costs because it uses a sliding fee scale for uninsured patients.

The Family Service Centers have received more community support and involvement than anticipated. Sources attribute this to the pediatrician's ability to develop rapport with her patients and their families. The coordinator believes that if the center had been assigned another doctor without the same interpersonal skills, the clinic would not have developed such a positive reputation so quickly. Staff also promote the family centers through school and community newsletters and by making staff available to address public groups. As interest in the centers grows, more community organizations and service agencies want to be linked to the center. However, space is limited and these additional services cannot be located at the center, which was originally intended for only the co-location of a nurse practitioner. After one year, the center is already considering plans for a larger facility.

Cultural Inclusiveness

The Fort Pierce community includes rapidly growing numbers of recent immigrants from Haiti and Latin America as well as migrant laborers. The health center's primary cultural concern has been the language barrier. Many staff members speak Spanish, including the pediatrician, but it is harder to find staff who speak Haitian

Creole. Parent educators from the Title I office, located next door, visit immigrant families at home to explain the center's services, but these populations are not yet fully served.

Implementation Issues, Barriers, and Solutions

Preferential treatment for students closest to the center. Because of the focus on serving the community rather than a single school, medical staff often do not know which school a patient comes from. However, Fort Pierce Elementary School students have priority for mental health services. This is a touchy subject among other agencies that use the counseling services and even among the counselors themselves, who say that the squeaky wheel tends to get the attention; by virtue of the clinic's proximity to Fort Pierce, it is easier for Fort Pierce students (and their families and teachers) to squeak the loudest.

Unrealistic teacher expectations. Health center staff found they needed to educate skeptical teachers about the programs and services available at the new center and convince them that efforts to work with the health center could be successful. But when teachers recognized the value of the health center, they developed unrealistically high expectations—for example, that they could send misbehaving children to the physician to be "fixed" through prescriptions for Ritalin or other medications. The site coordinator and principal solved this misunderstanding by inviting health center staff to eat lunch in the school cafeteria and to use the teacher's lounge for breaks to increase informal communication, so health staff could explain the difference between medical and non-medical sources of behavior problems. Teachers who have students receiving medical services meet regularly (often weekly) with the medical or mental health staff at the center to discuss progress, setbacks, and issues related to the student's situation. These steps increased teachers' understanding of the center's capabilities; teachers who have worked with the center staff feel positive about the experience and value the center as a resource.

Illiteracy. An estimated 35 percent of the adults in Fort Pierce are illiterate. They cannot read materials designed to make them aware of the available health services and are intimidated by the process of seeking help and having to admit their illiteracy. In addition, many people who may be eligible for Medicaid are not enrolled and do not seek services because they cannot negotiate the application process. Family center staff combat illiteracy through home visits to make potential clients aware of the clinic and by helping parents complete the required paperwork for Medicaid eligibility.

Accountability and Assessment

In 1994, the school district asked all agencies providing services through the health center to develop measurable, outcome-based treatment plans. The school district is developing a computer network that will allow schools and service agencies to share information on students in order to reduce paperwork, facilitate the transfer of information on families who interact with several agencies, and improve evaluation by linking school and service data. Confidentiality and security issues may present problems, however; many people are uncomfortable with the potential for misuse or unauthorized access. Information management staff are collaborating with the service agencies to develop security features, and attorneys are working on the legal aspects of security and privacy. Planners intend to start with noncontroversial information, such as immunization data and participation in early intervention programs.

Although FCHC is required to report data on its clients, the data that the school district would like to track are different from the data that FCHC tracks with its computers. Solving this problem has taken more time than expected,

so the district has not been able to get accurate school or student data regarding services.

FCHC tracked eight program goals and objectives for the 1993-1994 school year. For example, one stated that "FCHC would provide well-child screenings and immunizations to 1,200 children per year per provider at [two] elementary schools." The program reported achieving 64 percent of this goal. Another goal was to "provide early screening, diagnosis, and referral for treatment of lead poisoning in county children." The program achieved 93 percent of this goal. Another goal focused on providing outreach to community groups; actual achievement of this goal was reported as 100 percent.

Impacts

The centers have accomplished their goal of making health care more accessible to poor and uninsured children who would otherwise not receive health care. Since the family center opened, more children in the community have received health services, agencies and community groups have formed more cooperative relationships, and the costs to the school system have been limited.

School and service agency staff say the health center has generated a dramatic increase in compliance with appointments. Before the center opened, patients' no-show rates for recommended services exceeded 47 percent; compliance is now about 90 percent. More chronic health problems like asthma, diabetes, and seizures are being identified and better managed. And there has been an increase in the number of students with behavior problems who have been referred for treatment and/or counseling.

The school district and service agencies are just beginning to formulate more specific expectations for the centers, define these measures, and develop systems to track the necessary data. One challenge to measuring outcomes of the program on students and school performance lies in establishing a baseline from which to measure changes, because the mobility rate of students at Fort Pierce is very high (38 percent during the 1992-93 school year).

HealthNet, Inc. and Bridges to Success at School 50

Indianapolis, Indiana

- **Health center participated in a broader integrated services initiative to build support, minimize resistance, and obtain funding for a school-based program**
- **Involvement of many care providers improves students' access to services but makes coordination more challenging**
- **A managed care requirement for Medicaid participants is complicated by city-mandated busing**

Overview

HealthNet, a health organization under contract to a local hospital, operates three community health centers, one school health linkage with an elementary school, and one school-based clinic for a high school, in addition to providing the medical and health education components of Bridges to Success (BTS)[4] at two high schools. HealthNet collaborates with the school system, BTS, and many health and social service providers and organizations. Through these efforts, HealthNet served more than 7,000 children and youth in 1994.

HealthNet's BTS activity began in 1994-95. The linkage with the elementary school began in 1993, and HealthNet assumed responsibility for the school clinic in 1994. This profile focuses on HealthNet's BTS activity at School 50, which involved extensive planning and an early evaluation component.

Number of students served: 100
Grades served: K-5
Racial/ethnic breakdown: 50% Anglo, 50% African American
Eligible for public assistance: 75% public assistance, 80% free or reduced priced lunch
Major sources of funding: Robert Wood Johnson Foundation, United Way, local foundations

School and Community Context

Indianapolis (pop. 700,000) is the state capital and contains the headquarters for several insurance and pharmaceutical companies. The Indianapolis public school system includes the central city, in which 80 percent of the students receive free or reduced-price meals. Nine townships surround the city; each has a separate school system. Unemployment, crime, and gang activity are increasing throughout the city.

School 50, which has 455 students, is located on the west side of Indianapolis in a neighborhood that is 75 percent Anglo and mostly poor: 80 percent of the students receive free or reduced-price meals, and 75 percent are on public assistance. Many residents are Appalachian and move frequently between Indiana and Kentucky. Because of a city-wide racial desegregation order, 75 percent of the students at School 50 are bused from other neighborhoods. Half of these students are African American or belong to

[4]One of several local service integration initiatives across the country with funding from a private foundation.

other minority groups. Although there is not a full-time school nurse, a nurse from the county health department visits the school for two hours a week to maintain student health records and examine sick children.

Major Program Features

School 50's school-based health center offers primary care for elementary school students. The health center is part of BTS, a community initiative that brings health and human services to schools. The health center and other BTS programs began implementation in 1994 after several years of planning.

Planning Process

BTS began in 1992 at the instigation of the local United Way president and the superintendent of Indianapolis schools, who convened a meeting of community leaders to address the health and social service needs of children and families through increased school-community collaboration. Participants included a coalition of community leaders who support education, a county health and hospital corporation, a city network for employment and training, local community centers, and the Chamber of Commerce. A core planning group dedicated 10 percent of their time to developing the initiative; they held a planning retreat and met regularly to identify implementation steps, review needs assessments, and plan linkages with the schools. These organizations sought to reduce service duplication and viewed schools as the best way to reach families in the community.

BTS members interviewed parents and community leaders—clergy and business people—to identify the issues that affect student achievement. BTS also conducted focus groups, telephone interviews, and surveys of residents to identify health care issues, and asked teachers, students, and health care providers to identify student needs. An analysis concluded that health care issues often interfere with students' education, especially malnutrition, head lice, and fevers. BTS connected School 50 to HealthNet, which obtained a foundation grant to pay for a nurse practitioner and a family services coordinator.

Planners briefed school administrators on the plan and invited them to apply to participate. BTS selected six of the 25 applications on the basis of geographic distribution, social and academic needs, varying level of experience with community collaboration, and racial mix. In early 1993, these schools developed plans and formed school-based planning teams. At the sites served by HealthNet, participants included principals, parents, a HealthNet representative, the county medical director, and a BTS member.

HealthNet planners saw the BTS initiative as a way to reach a broader community and to facilitate collaboration among organizations to address multiple health and human service needs. However, the large number of organizations involved in the initiative slowed and complicated the planning process as members of the planning team negotiated every aspect of collaboration between the schools, the health care providers, and BTS. "There was a form and a meeting for everything from what services the clinic would provide to what color the walls in the clinic would be painted," recalled one administrator.

Protocol development delayed planning for the school-based health center. Administrators from HealthNet, BTS, and the school system developed contracts outlining each organization's responsibilities and authority. Turf issues surfaced when schools resisted relinquishing authority over a school-based program while HealthNet insisted on following service protocols and guidelines consistent with regular medical practice. The contract included a confidentiality clause that prohibited the organizations from releasing medical records without permission and established a reporting system consistent with all collaborators' policies. HealthNet assigned its

school coordinator to supervise the school clinic's medical staff, a position that was not outlined in earlier negotiations. Because HealthNet contracts with a hospital, school-based medical staff must follow the medical protocols used by the hospital.

Logistical issues also posed problems for planners. School 50's health center opened before its permanent location was renovated—but the temporary location did not have a secure place to store medical supplies and equipment, and the room was used by students when the nurse practitioner was present. As a result, the nurse practitioner could only perform treatments with the supplies she carried in her medical bag, which limited services. In addition, implementation was delayed because planners did not adequately address budget issues. Grant funding did not cover the costs of telephones, medical supplies, and equipment—expenses that HealthNet ultimately assumed.

Program Design

The school-based health center at School 50 is designed to provide immunizations; sports and general physical exams; pregnancy testing (but not contraception or referrals for contraception); management of chronic illnesses such as diabetes or asthma; nutrition, substance abuse, and mental health counseling by a social worker; and violence or conflict resolution, although not all services are fully implemented yet. Students who need X-rays or urgent health care are transported to the community medical center or hospital. The family service coordinator also works regularly with 10-15 students at School 50 who suffer from chronic health conditions.

The health center is open from 8:30 a.m. to 11:30 a.m. on school days. Teachers refer students to the clinic's social worker, who discusses each case with a family service worker; the nurse practitioner sees patients on an as-needed basis. School 50 provides a room for the health center, and the county health department provides computers that are linked with HealthNet and other health care agencies and hospitals. The computer system enables the nurse practitioner to obtain more complete medical histories; this is especially important for young children who often do not know which services they have received. The clinic is located in an annex on the school campus. School staff bring children to the health center or send them through the principal's office. Students do not need appointments to receive treatment, and although parents are encouraged to accompany their children, they do not have to be present for the child to receive services.

Parental consent and confidentiality. HealthNet and School 50 each require parents to sign a form releasing their child for treatment. HealthNet's permission form includes a brief medical history. School 50 also issues a consent form to the parents to release confidential information about their child to the BTS social worker. Less than half of the parents have returned these permission slips, but most parents consent to treatment when their child is ill. HealthNet attributes the low response to the fact that some children already have a primary medical provider. If a sick child who does not have a signed permission slip comes to the clinic, staff try to contact parents.

Confidentiality. HealthNet, the school system, and BTS together developed guidelines for gathering and reporting information on student patients that do not violate the confidentiality guidelines of any of the organizations. The family service coordinator revised intake and evaluation forms to conform with school rules and planners developed two consent forms: one that allows children to use the health center and another that permits the BTS school advisory team to discuss the child's case. The clinic nurse is obligated to keep students' health matters confidential, and by law parents do not have to be told if their child has a sexually transmitted

disease (STD) or is pregnant; but clinic staff cannot counteract school policies, which include informing parents of a child's life-threatening conditions.

Organizational/Management Structure

HealthNet and School 50 share management of the school-based health center. A HealthNet school coordinator and the BTS specialist meet weekly with medical staff to discuss the health center and ensure quality control. The HealthNet coordinator, who is based at the high school but oversees three centers, is responsible for the maintenance and day-to-day operation of the school health center. The district's director of nursing and health services meets regularly with the HealthNet school coordinator but does not play a direct role in service delivery.

Staffing

Like all BTS schools, School 50 has a full-time, on-site BTS coordinator whose salary is paid by the school district. The health center at School 50 shares a nurse practitioner with another school but has its own full-time family service coordinator. The nurse practitioner, who specializes in pediatric nursing, previously worked with a pediatrician at one of the HealthNet community medical centers. The family service coordinator has a master's degree and is a certified social worker. HealthNet also has a school coordinator who supervises the school-based staff. A financial planner from HealthNet visits School 50 to enroll families in Medicaid and discuss the best options for paying for medical care.

HealthNet hired the clinic's medical staff with input from a school team that included the principal and BTS specialist. Planners focused on finding staff who could work well with the school principal; HealthNet found it difficult to find a nurse practitioner who was willing to work in a school environment, could meet the medical qualifications, and would accept the salary level they could provide. Because HealthNet contracts with a hospital, medical staff are considered hospital employees who are entitled to attend conferences, visit other health clinics, and participate in other professional development sponsored by the hospital.

The family service staff and the school social worker jointly review cases and divide responsibilities, which takes some of the workload off the school social worker. School administrators initially worried that the school social worker's position would be eliminated when the school clinic opened, but the heavy caseload justified both positions.

Funding and Reimbursement

BTS received $439,300 in start-up funds from the Robert Wood Johnson Foundation for school-based and school-linked services at six pilot schools, two of which have programs operated by HealthNet. The programs also receive matching funds from the city, local foundations, United Way, and a local coalition of community leaders. Most of HealthNet's allocation is devoted to salaries and benefits for the clinic's nurse practitioner and family service coordinator. HealthNet has absorbed the costs for telephones, medical equipment, and medical supplies (some of which are donated by a local hospital) and contributes some staff time for the school coordinator and a financial planner who enrolls families in Medicaid. The schools provide space for the health center, custodial services, and office furniture.

The Robert Wood Johnson Foundation grant covers all of the school-based center's medical services for the first year of the program. After 3 years of implementation, the health center must assume responsibility for salaries for the nurse practitioner and family service coordinator. HealthNet plans to cover its costs through Medicaid reimbursements. However, Indiana's managed care system requires Medicaid patients to select a primary care physician. Reimbursement is not a problem for clients who have selected a HealthNet physician as their primary provider,

but when this is not the case HealthNet must absorb the cost of services. HealthNet administrators hope that the state will grant a waiver to health centers, allowing them to bill Medicaid for services delivered by non-primary providers. But administrators also fear that HealthNet may have to reduce the nurse practitioner's hours at the school-based clinic or eliminate her position entirely if the clinic does not obtain enough reimbursements to cover service costs.

Family and Community Involvement

The BTS planning committee involved parents, students, and community leaders in designing and implementing the school-based health center. The United Way, which was responsible for BTS community outreach, met with parents, spoke at parent-teacher group functions, distributed flyers, and sponsored television commercials advertising the school health link. A representative from the health center was available to answer questions during school registration. School administrators credit these efforts with encouraging parents to grant permission for their children to use the health center.

Through Bridges to Success, HealthNet has expanded its efforts to serve the larger Indianapolis community. Although the school clinic does not treat students' family members, HealthNet staff are available on BTS family nights to provide health information and encourage parents to visit one of HealthNet's community health centers. The family service coordinator and the nurse practitioner make home visits to sick students. HealthNet also runs three community medical centers that provide comprehensive care. HealthNet staff have admitting privileges at a local hospital.

Community outreach at School 50 is hampered by the fact that 75 percent of the students live in other communities and are bused to school. It is often unrealistic to expect students and their parents to use the HealthNet medical center located near the school. HealthNet can encourage parents of Medicaid patients to choose a HealthNet physician as their primary care provider, but the HealthNet medical center may not be convenient to the family's home.

Implementation Issues, Barriers, and Solutions

Involvement of many organizations encourages bureaucracy. The involvement of many collaborators resulted in some turf issues. Although each collaborator had the best interests of children in mind, they approached the solution from different angles. Planners found it hard to get people to agree on the issues; even hiring staff required coordinating decisions by BTS, HealthNet, school system, and school participants.

Communication barriers between the medical and education communities. Health center staff found it hard to explain to schools that a nurse practitioner does more than the traditional school nurse; some principals, on the other hand, wanted to have complete authority over the clinics, including staff hiring and supervision, because the clinics are part of the school. HealthNet's contract with the school system gives the health center control over the clinic and services. However, this situation often traps the medical staff between HealthNet and the school.

Coordination with school schedules. Clinic staff have learned to coordinate carefully with teachers to avoid concern that students will miss classes to receive health services. Although appointments are not necessary to use the health clinic, students must be referred by a teacher or school administrator. Clinic staff also reschedule planned events, such as removing students from class to check for head lice, if teachers protest that it will interfere with study or test schedules.

Accountability and Assessment

Clinic staff are evaluated according to guidelines established by HealthNet and the hospital with which it has a contract. This involves a peer review of medical charts at the end of the

school year. The school coordinator also reviews charts periodically to monitor service quality.

BTS hired an independent consultant to evaluate the program's processes and outcomes. The consultant released summaries of the program's key concepts and strategies and an interim evaluation in 1994. The evaluator's data come from on-site interviews, focus groups with parents and community members, and reports from on-site coordinators; evaluation topics include services provided, strategies used, implementation issues, and barriers.

Impacts

It is too early in the program's implementation to link it with many impacts, but school administrators hope that the clinic will improve attendance rates, reduce the length of absences, and create a positive environment for students through preventative health care, mental health services, and assistance to families in crisis.

A 1994 interim evaluation found mixed results of the BTS initiative:

- Views on whether integrated services should improve students' academic performance varied. Some sources thought it was essential to identify a link between services and performance, while others thought that students deserved comprehensive assistance whether or not it improved school performance.

- Bringing private organizations into the schools for collaboration was usually not a complicated effort, often because these organizations are looking for space and schools have facilities to offer.

- The site-based teams that developed the programs worked well together, probably because they grew used to developing consensus as they worked out the original site plans. However, the site teams are in danger of losing momentum and focus; keeping them intact and productive as implementation gives way to ongoing operations will be a challenge.

- BTS hoped its comprehensive approach would protect schools from being overwhelmed by reforms, but it appears that BTS's organized structure for collaboration leads to a temptation to use the project to explore any new idea.

- The program has not yet found a balance between site autonomy and tailored services or central control and standardized services. Lack of resolution on this issue has created some confusion and resentment.

- The roles of the policy and steering committees are ambiguous and need to be redefined.

Konawa Community Health Center and Pleasant Grove School

Konawa, Oklahoma

- **School-linked mobile van provides health education, screenings, basic services, and referrals for children and youth in eight rural communities who cannot afford other health care options**

- **Interactive computer and video equipment on the van enables health staff to send patients' vital signs to medical specialists at the main health center; off-site doctors can see and speak with patients at the mobile clinic, enhancing communication and maximizing the services available to patients**

- **By sharing curriculum plans with parents and parent-teacher groups, clinic staff meet the drug prevention and sex education needs of adolescents while alleviating concerns in a conservative community**

- **School staff serve on health center governing boards and clinic staff attend school meetings to foster communication**

Overview

With a mobile van and three staff members, Konawa Community Health Center provides general physical exams, health and sex education, and Head Start screenings to children and youth in eight rural communities about 65 miles southeast of Oklahoma City. Other staff based at the center serve additional children and families with referrals. The sex education program began in 1989, followed by the van in 1992. This school-linked program serves about 5,700 students a year who often cannot afford other care because they lack insurance or their parents are unemployed.

Number of students served: Approximately 5,700 students (12,000 contacts) in 1993
Grades served: 1-12
Racial/ethnic breakdown of entire service area: 90% Anglo, 5% Native American, 2% African American, 3% other.
Eligible for public assistance: 85% receive free or reduced-price lunches.
Major sources of funding: Federal grants, Medicaid/Medicare reimbursement, patient fees, local foundation, some state funds

School and Community Context

Konawa, a rural community with 1,600 residents, recently has endured huge cutbacks in jobs at a local factory and a power plant. A public K-12 school draws students from four nearby towns. There are five small hospitals and several private physicians within a 35-mile radius of Konawa, but many residents cannot afford either option. A nearby Native American Hospital offers free services and medication to Native Americans, but some patients prefer to receive care from the clinic because it is easier to schedule appointments and they can see the same doctor each time. There are no school nurses.

Konawa Community Health Center is located three blocks from the city's only public school but serves clients from as far as 45 miles away. More than half (55 percent) of the clinic's clients are uninsured; about 20 percent have Medicaid, 17 percent have Medicare, and 8 percent have other insurance. Sixty percent of the clients are female. Approximately one-third of the clients are below age 20 and slightly less than one-third are between the ages of 20 and 44. Almost one-fourth are between the ages of 45 and 65. Many students are referred to the clinic for services related to Attention Deficit Disorder (ADD), although medical staff say the students often need family therapy instead. Other major medical needs are for dental care and nutrition education, especially for eating disorders.

Pleasant Grove School, located 15 miles from the health center, serves 148 students in grades K-12. It is profiled here because it has one of the largest populations of students needing support services among the schools served by the mobile van. Seventy percent of Pleasant Grove's students come from families with incomes less than $20,000; 95 percent are eligible for free or reduced-price meals. The school has had a Title I schoolwide program since 1991. Seventy percent of the students are Anglo, 20 percent are Native American, and 10 percent are African American.

Major Program Features

The mobile van program is a major element of Konawa's school-linked health services. A key component is a teen pregnancy prevention and sex education program, implemented in 1989 to combat the state's high teen pregnancy rates, that was incorporated into the mobile program when it began in 1992. The health center serves about 50 clients a day; the mobile van serves an additional 25 to 30 clients daily. All children and youth are eligible for services, although the clinic especially targets a small group of clients who do not receive other health services. The heaviest users of the clinic are children between age 8 and 14 who receive dental, vision, and hearing services, and youths between age 16 and 17 who receive family planning. There is no waiting list for services.

Planning Process

The teen pregnancy program that formed the basis of the mobile health unit was designed in 1988 by a licensed practical nurse (LPN), a registered nurse, and the administrative director of the community health center as part of a statewide response to the fact that Oklahoma had one of the highest teen pregnancy rates in the country. The LPN had great freedom to develop the program on her own, with feedback from the health center's medical director. The LPN attended school staff meetings to inform principals and teachers of her plans and to receive their input. The link to schools was established by the health center's administrative director, who contacted the school board to establish an agreement. The comprehensiveness of the program was determined by balancing the medical staff's goals with teachers' concerns. Sources noted that in this rural area, schools are the center of the community; planners had to gain the trust of teachers and parents who were involved in the school in order to gain the support of the rest of the community.

The sex education program, implemented by the LPN and registered nurse, targeted students in grades 7-12 in eight schools. In 1992, budget cuts eliminated the registered nurse's position; at the same time, state law mandated the addition of AIDS education and the clinic added a health and sex education program targeting students in grades K-5. Because Konawa is a conservative community—and sex or drug education is controversial—parents and community members have become important participants in the clinic's annual curriculum planning process. During the first years, the LPN presented her curriculum to teachers, PTAs, and advisory boards annually to negotiate the contents. The LPN viewed this as an opportunity to strengthen

the linkage between school and health center by educating parents about the clinic's efforts and services. After assuring community members that the program is fact-based and does not present values or personal opinions, the LPN has gained the community's trust and no longer must defend her curriculum.

Program Design

Mobile services. The mobile van, staffed daily by a nurse practitioner and nurse/clerk and weekly by a physician, visits two towns a day on Mondays, Tuesdays, and Wednesdays—operating from 8:30 a.m. to noon in one town and from 12:30 to 4:30 p.m. in the next. On Thursdays and Fridays, the van visits one town a day, to serve a total of eight towns a week. The mobile van can set up at any location where it can plug into a generator—usually a school but sometimes a nursing or nutrition center.

The van offers a teen pregnancy prevention program for students in grades 7-12 at about a dozen schools in the area; these services include education on AIDS/HIV, sexually transmitted disease prevention, reproductive biology, sexual responsibility, self-esteem, hygiene, and birth control distribution ranging from condom distribution to prescriptions. A sex education program for younger students deals with puberty changes, hygiene, self-esteem, and sexual abuse. Each school chooses which services to accept, although the AIDS/HIV component is mandated by the state. Other mobile services have include general health screenings (i.e., gross dental, vision, hearing, height and weight measurement, blood pressure, scoliosis and child abuse checks); head lice examinations; WIC services; immunizations; and vaccinations for faculty members. However, in 1994-95 the grant that paid for health screenings expired, and so far no schools have signed up to pay for services other than the state-mandated HIV/AIDS education and sex education. Sources say the schools want the additional services but can't afford them.

In July 1995, the mobile van acquired interactive computer and video equipment that links the main health clinic with the mobile unit. Funded by grants from Southwestern Bell, a private foundation, and the state, the "tele-medicine" option enables medical specialists at the main clinic to "see" and speak to patients on the mobile unit, while on-site practitioners send the patient's vital signs via computer hook-up. This capability helps the project maximize services and staff throughout the large, rural area.

Sports physicals and Head Start screenings. The health center conducts between 1,500 and 2,000 sports physicals a year to students in the Konawa area. The center also conducts screenings for most of the area's Head Start programs. Screening results are sent home with students; if anything abnormal is identified (about 30 percent of the cases), parents also receive a list of follow-up resources. Clinic staff call these providers to see whether the students follow up on the referral, but find that the students can't always afford to visit the providers to whom they are referred.

Ambulatory family services. The health center serves students' families through a small emergency room, a small X-ray lab, prenatal care, primary care for newborns, and in-home geriatric care. In 1993, the center added WIC services including nutrition education classes for parents, child care education, and periodic nutrition assessments for children.

Referrals and parental consent. Students under age 18 must have parental consent to receive most clinic services except birth control, which is exempt under state law. Consent forms must be signed in front of a clinic staff witness—on the mobile van or at the health center—so parents must accompany their children on their first visit. Consent is not required for sports physicals or for birth control for youths above age 12 who declare themselves sexually active. There is no expiration date on the consent forms.

There is no formal process for referring students to the health program. At Pleasant Grove, teachers call the principal or clinic's registered nurse to refer students to the health program. Sources do not report any problems with this informal system. Clinic staff refer about half of the students to outside providers for dental care. About 35 percent of the students need referrals for vision care, and 60 percent receive referrals for hearing problems. The program does not make referrals for reproductive services.

Integration and coordination with education program. This program is not extensively integrated with the school curriculum, although the school system's education coordinator is collaborating with the health center's physician to design a program for students who are interested in medical careers; this would combine classroom work with volunteer work at the health center. The school-linked program is coordinated with school staff only through the feedback that teachers provide to the LPN who runs the sex education component, and by the fact that the principal and teachers refer students to the program. The lack of integration and coordination may be related to the large number of students who are served by the program's limited staff; clinic staff simply haven't had time to develop stronger ties with the schools.

Organizational/Management Structure

The community health center's medical director and administrative director oversee the school-health program and report to a 24-member board of directors. The health center's director of nurses and the director of the mobile unit report informally to the medical and administrative directors, often daily. The director of nurses supervises six LPNs, registered nurses, or certified nurse aides. A liaison between the schools and the clinic oversees sex and HIV/AIDS education components that the program conducts at 12 schools.

The board of directors oversees finance, quality assurance, executive decisions and policies, membership, personnel issues, program records, marketing and advertising, and facilities for the school-health linkage. Only the finance and quality assurance groups meet regularly; the rest meet only to address issues that arise.

School and health center leaders are very close. Two school board members and four teachers sit on the health center's board of directors, and the vice president of the health center board is also the director of community education for the Konawa Public School. Six school administrators sit on health center policy boards; school and clinic staff attend each other's board meetings; and the health center's family nurse practitioner is the "physician" for the school's football team. The Pleasant Grove principal and clinic staff communicate constantly through memos or by telephone.

Staffing

Staffing has been a continual problem for the health center. Local business owners first attracted a physician to the area in 1964, by forming a non-profit organization that provided loans to a medical student. After graduating, the new doctor practiced in Konawa for five years, working at a clinic built by the local utility company. When the doctor moved to another community to open his own practice, Konawa replaced him with a succession of physicians, each of whom stayed for one or two years. At times, the clinic had to operate without a medical director or with only part-time services. Konawa's community health center opened in 1984, with funding from the Public Health Service. Physicians hired by the health center, most of whom are identified through the federal medical school loan repayment program, continue to move on about every two years. Administrators trace the frequent turnover to two factors: (1) serving such a large population produces burnout, and (2) many physicians can

earn more by starting their own practices (although in recent years the clinic's salaries have become more competitive.

The clinic's current staff includes a fulltime physician/medical director, who oversees the medical team and the program's day-to-day operations; a part-time physician; a fulltime physician assistant; a full-time nurse practitioner; two registered nurses; three LPNs; a certified lab technician; an X-ray technician; an administrative director; and a financial officer. The director of nursing coordinates nurses' schedules and works in the clinic. A financial officer helps clients enroll in Medicaid. The registered nurses and LPNs conduct screenings and immunizations and take medical histories. The medical director examines patients and coordinates quality assurance. Student nurses from four nearby vocational-technical schools and colleges gain clinical experience by helping health center staff. As a result of these connections, the program hires most of its nurses from these universities.

Funding and Reimbursement

The program's annual budget is approximately $300,000 for the mobile unit and $800,000 for the health center. The mobile unit was initially funded by a three-year outreach grant from the federal Office of Rural Health; since the grant expired, the mobile van has been funded by patient revenue. The center receives $350,000 in federal funding, $300,000 in reimbursement from Medicaid and private health insurance companies, $75,000 in state funding, and $50,000 from the Presbyterian Health Foundation. In 1994, the clinic used $4,000 to purchase a second mobile unit.

The health center uses a sliding fee scale based on family income and size; the balance is subsidized by Section 330 federal grant money. Medicaid rates are negotiated yearly; currently, the center is reimbursed $97 per visit for Medicaid patients. The health center is responsible for billing Medicaid.

When the sex education program started, schools supplied materials while the health center provided staff to teach the classes. After two years, however, budget cuts eliminated the funding for materials and the health center began to charge the schools for services. The number of patient contacts decreased from 12,100 in 1993 to 8,000 in 1994. Administrators do not know whether the number of patients similarly decreased or how many of the lost contacts were for students and how many were for other community members.

Family and Community Involvement

When the health center acquired its first mobile unit, organizers held a student art contest to develop a logo for the unit and to stimulate community interest in the school-linked program. Several hundred students from all the schools served by the mobile unit entered the contest, and a state legislator presented the prize, a $100 savings bond. The health center battles a lingering stigma that it is a free clinic for poor people, rather than a community clinic for all residents. This is not a problem for the van, which travels to distant communities. Staff have tried to change public perceptions by offering inoculations to teachers to increase awareness.

Implementation Issues, Barriers, and Solutions

The center's community role has been erratic. The health center's turbulent, 20-year history in Konawa has created both tension and support in the community. When the center lost its physician and closed temporarily, the city considered selling the building to a nearby hospital but community members resisted having an out-of-town organization take over the clinic. In addition, the clinic struggles between meeting the acute care needs of its low-income clients and providing the preventive care required by its Healthy People 2000 funding. The school-linked program provides the clinic with a way to do both.

Confidentiality and privacy can be hard to maintain in a small-town setting. To protect the confidentiality of students who receive reproductive services from the mobile unit, clinic staff remove the information from the student's medical chart if he or she visits the clinic with a parent for another medical reason. Staff from the mobile unit thought this strategy would attract students, but because the van is highly visible in the small towns, students who want sex information often feel they lack privacy. These students usually visit the mobile unit when it stops in neighboring towns.

Limited space, combined with increasing need for services, will require expansion. The health center outgrew its 7,500-square foot facility and added a second mobile unit to expand services to school children and their families. The clinic received federal funding to expand in 1995.

Schools are reluctant to take on some health roles. In an effort to save the schools money, the clinic's medical director suggested that his staff teach teachers how to check students for lice, so they wouldn't have to contact nurses for this service. But schools were concerned that parents would be angry with teachers who found lice in their children's hair, and declined.

Small towns encourage a duplication of roles among care providers. The health program's administrative director is also a board member of a local mental health service. The health center's medical director is also director of a nursing home and works in the emergency room of a local hospital. The family therapist who works with the health center's medical director is also the town priest; the center's family nurse practitioner travels with the school football team as its "physician"; and the center's director of nurses is also the local WIC coordinator.

Accountability and Assessment

This program gathers minimal data (e.g., the number of face-to-face contacts, the number of immunizations and screenings) and does not use the data for any specific purpose. Program self-assessment is addressed quarterly, when the supervising physician randomly reviews charts to check compliance with protocols, staff credentials are reviewed, the staff discusses procedures and examines equipment to address safety issues, or staff conduct a patient satisfaction survey. The nurses meet with the director of nursing as needed to discuss quality concerns.

Impacts

The expected outcomes of this program are to improve general health—vision, hearing, and nutrition—and school performance. The program does not have statistical support for these outcomes but offers anecdotal evidence, such as pregnant students who have been able to stay in school because the program helped them obtain WIC services, prenatal care, and nutrition education.

The Pleasant Grove principal, who shares the clinic staff's definition of successful outcomes, says the health linkage allows his school to meet state health screening requirements. About one-third of this school's students need follow-up services—a need that would be undiagnosed without the school-health linkage. Although the principal does not note an impact on school attendance, he says the health program improves student performance, especially among students who receive vision and hearing treatment, and has improved students' knowledge of sexually transmitted diseases and HIV/AIDS. The linkage with the health center also has decreased some of the burden on staff and teachers to address their students' multiple, nonacademic needs.

Logan Heights Family Health Center and The Place: An Alternative School for Homeless Youth

San Diego, California

- **Serves extremely high-risk and needy youth**
- **Based on an informal, simple service agreement**
- **Provides basic services at the school one day a week plus extensive referrals and transportation to the school clinic and main health center**

Overview

Logan Heights Family Health Center's school-linked health care program began in 1993 when the center received a Healthy Tomorrows Partnership for Children grant to take comprehensive, case-managed medical care to locations where homeless, runaway, and near-homeless teens gather. A Medical Health Outreach Team (MHOT) composed of health center medical staff provides weekly clinical services at The Place, an alternative school that serves homeless and runaway adolescents in inner-city San Diego.

Number of students served: Approximately 200 patients a year
Grades served: Patient ages range from 0-20 years; most are between 16 and 19
Racial/ethnic breakdown: 67% Hispanic, 13% African American, 19% Anglo, 1% other
Eligible for public assistance: 50-60% are eligible, 10-20% receive assistance
Major sources of funding: Federal grants (Healthy Tomorrows, Health Care for the Homeless, Healthy Schools/Healthy Communities)

School and Community Context

The health center, which has a 100-year history, has operated in its current form for 25 years in a community known as "Barrio Logan." In the early 1990s, the neighborhood had only one primary care physician for every 7,677 residents—and a poverty rate of 30 percent. The health center, which has a staff of 300 and records approximately 100,000 patient contacts a year, has the largest freestanding HIV/AIDS clinic in the county and also operates three satellite clinics in addition to the school linkages. The Place is an alternative school located in "the combat zone," one of the roughest and most drug-infested areas of San Diego. The Place, which opened in the late 1980s and typically serves about 50 youth at a given time (approximately 500 a year), uses showers, food, clothing, and the promise of a safe haven to lure youth off the streets—and then tries to hook them on education in exchange for these staples.

The county estimates that there are between 1,200 and 1,500 runaway or "throwaway" homeless youth who have run away or been thrown out of their homes, and who now live on San Diego's streets for extended periods. A health center staff member estimated that 98 percent of these youth have been physically and/or sexually abused, many have severe drug and alcohol abuse problems, more than 60 percent of the girls have been pregnant, and 50 to 75 percent of both genders engage in "survival sex" that brings them money for food, clothing, and shelter. These youth have a very low level of trust for

adults and formal institutions; most would not seek medical care directly despite availability of services.

Major Program Features

The Logan Heights medical team visits The Place one day a week to provide primary medical care and health education to students. The health center also has an outreach worker who drives the area in a van, looking for youth in need of medical services.

Planning Process

This project began as an effort to increase access to health care among adolescents and to coordinate the efforts of various health center departments including obstetrics and gynecology, pediatrics, peer education, and HIV testing. The project was initiated by the health center's medical director, who has a long-standing commitment to serving the healthcare needs of disadvantaged, especially homeless youth; the director of the center's Health Care for the Homeless grant, who obtained the founding teacher's support for the project; and the director of program development, who helped shape the plan into a grant proposal. The team's first grant proposal was rejected in 1992; planners linked the project with a second proposed grant to target tuberculosis among homeless youth, resubmitted it, and received funding in 1993. Planners visited a health care program for homeless patients at a hospital in Los Angeles to learn about policies and legal issues involved in delivering services; the team also drew on lessons learned during the health center's recent establishment of a walk-in teen clinic at the health center, which had raised turf issues among the large health center's many departments.

With very little formalization of their plans beyond the grant proposals, and using standard protocols developed by the health center, clinic staff began providing services at the school. To raise community awareness, staff sent flyers describing the program to other service providers in the community and to hotels frequented by homeless youth.

Program Design

The arrangement with The Place was the health center's first effort to provide off-site, school-based services to the community. The storefront school provides one exam room (a former closet) and some administrative space (the principal's office) for the MHOT team's visit every Thursday, and staff use a hallway outside classrooms to record medical histories. (Program directors are trying to secure funding to redesign a storage space to provide more space and an additional exam room. Currently, staff do not maintain any medical records at the school because of concerns about confidentiality.) The school also provides custodial services, a telephone, a refrigerator for medicines, and counselors.

The project's primary goals are pregnancy prevention and screening for sexually transmitted diseases and tuberculosis. Because the program does not have much medical equipment other than that which staff can carry with them, on-site medical services are limited to screening (primarily for tuberculosis, deficient immunizations, sexually transmitted diseases, and high-risk behaviors), diagnosis, and basic primary care. Students needing ear/nose/throat, endocrinology, or obstetric/gynecology services are referred to specialists at the main clinic. Health education is provided on an individual basis, as needed. Clinic staff send prescriptions to the Logan Heights health center to be filled, and the outreach worker or school staff bring the medications back to students.

School-linked clinic staff use the same medical protocols used by the health center but are developing protocols for the clinic's specific needs, including case management and registration of homeless patients. Health services provided at the school site are covered by the health

center's malpractice insurance policy; at two other school-linked sites where Logan Heights is initiating services, the school nurses operate under protocols and supervision given by the health center's medical director and are therefore covered by the health center's insurance.

Once a week, the project coordinator transfers information from patient encounter charts to case management cards that are filed in a box; staff carry the box with them when they visit the school. The cards list the dates of service, type of visit, diagnosis, referral information, and follow-up frequency for each patient. Three days before staff are scheduled to visit The Place, the coordinator faxes a list of patients to the school to ensure that the medical records are available on site (although the clinic also takes walk-in appointments).

Based on its success at The Place, Logan Heights is expanding its school-linked health services to an elementary school and to a community center in an area fraught with poverty and homelessness. The new sites offer more space, a more traditional school clinic setting, and more hours of operation, so the program can offer more comprehensive services at these sites; but planners expect family planning services and parental consent issues to present problems that they have not encountered when treating the more emancipated homeless youth.

Referrals. Students who need services that the on-site clinic can't provide are referred back to the main health center or other providers. Most referrals are for dental care (100 percent of patients), social services (50 percent), and drug or alcohol abuse treatment (25 percent). Although the medical director has many contacts in the community—he also serves on the staff of the local children's hospital—clinic staff find it difficult to obtain referrals for uninsured patients. And although the clinic provides transportation to the health center two days a week, and staff try to schedule referral appointments on these days, between 20 and 30 percent of the students referred for medical services and between 80 and 90 percent of the students referred for dental services do not keep their appointments because they can't afford the services or do not qualify for assistance such as Medicaid. The clinic's nurses find it hard to monitor referrals because the students are so transient. The project coordinator calls case workers at the homeless shelter used by many students to remind them of the students' referral appointments, but she says that many students miss three or four appointments before receiving services.

Parental consent. State law allows anyone age 12 or older to seek contraceptives or treatment of STDs and other communicable diseases without parental consent. Because most of the students are seeking contraceptives, staff can treat them without parental consent—which is especially important because these patients are usually estranged from their parents and unable to obtain consent. However, consent is a problem for non-sexually active teens unless they are emancipated minors living completely without family support. Medical staff are still searching for ways to resolve this problem.

Confidentiality. This program has blanket consent forms that allow the various providers to share information to support case management, but clinic staff acknowledge that they do not use the forms consistently because the program has not had a formal policy on this matter. Program administrators are developing policies, forms, and care plans to address this and other operation issues.

Organizational/Management Structure

This project is managed by the health center's medical director—the driving force in terms of philosophy and organization—who spends about 15 percent of his time on the project; the health center's director of program development, who spends about half her time on the project;

the director of the center's Health Care for the Homeless grant, who provides technical assistance; and a fulltime on-site director. The directors meet formally every month but in reality have contact much more frequently. Because the project is relatively new and small-scale, this informal process has been adequate, but the program recently acquired a project manager to formalize procedures and monitor day-to-day management issues. The medical director heads the MHOT team that provides on-site medical services.

The primary collaborators from the education program are the head teacher, who helped develop the idea of the health program and now takes a supportive but hands-off approach, and the director of the county's juvenile justice schools, who has jurisdiction over the alternative schools and is very supportive of the health linkage. An advisory group, required by the Healthy Tomorrows grant, has some oversight of the program; health center staff try to use the group for policy issues rather than governance. Twice a month, staff from the school and a local shelter meet informally with medical and case management staff to coordinate their efforts.

Staffing

The medical team is the core of the project's services; it includes a physician, a registered nurse/project coordinator, a physician assistant or nurse practitioner who assists the doctor, a medical assistant, and a medical services representative who handles paperwork. Additional staff include an outreach worker who was a physician in Mexico but is certified as a medical assistant in the United States and a state-certified contraceptive counselor specializing in risk assessment and HIV counseling and testing. All staff have a strong interest and range of experience in treating adolescents. Staff development is very minimal and usually consists of attending annual conferences through the health center.

Health administrators view the coordinator's position, added after this project began, as especially important to the school linkage because this person is responsible for activities that the medical staff have neither the time nor the training to do well: community outreach, coordination with other community groups, and evaluation. The coordinator also offers a broader perspective that includes experience outside the public health field, which administrators say is valuable to a program that operates outside the standard health center environment.

Funding and Reimbursement

The seed money for this project came from a Healthy Tomorrows grant of $50,000 a year for five years, and from a one-time $123,000 federal grant under the Stewart B. McKinney Act (targeting homeless populations at risk of tuberculosis). The Healthy Tomorrows grant comprises approximately one-third of the medical team's operating budget. Public Health Section 340 funding is viewed as essential to the school-health program in San Diego. "If we don't get 340 money, we don't do healthcare for the homeless," one administrator said. Major costs in this program are for salaries, insurance, and medical supplies.

The health center is the lead agency in San Diego County for Health Care for the Homeless funds, and some of this funding also supports school-based services at The Place although it is viewed as a last resort. Other income comes from the Children's Health and Disability Program (CHDP), the California equivalent of EPSDT; a CHDP treatment fund covers treatment for conditions diagnosed during CHDP screenings. The health center also pursues third-party billing, but few clients have insurance and staff report no success in obtaining reimbursement from managed-care providers.

Students who belong to managed-care programs can receive initial treatment from the clinic at The Place but are then referred to their primary providers; if the same patients tried to receive services at the main health center, they would first be referred to their primary providers and the center would provide follow-up.

Although some students are eligible for Medicaid (MediCal), they are often non-emancipated teenagers and establishing their eligibility and gaining consent from their estranged parents is difficult. The program also lacks the time and staff to help eligible students apply for Medicaid. In these cases, the school-linked program provides services at no cost.

Family and Community Involvement

Because most clients at The Place are runaway or "throwaway" youth, family involvement is not usually possible or sought. However, case managers at the health center, school, and shelter do pursue family reunification whenever possible.

The positive reputation of the weekly teen clinic that Logan Heights operates at its main health center has helped attract patients/students to the clinic at The Place. The project coordinator also makes health presentations at schools and homeless shelters to raise awareness of the clinic.

Cultural Inclusiveness

All staff are bilingual and almost all are of Hispanic descent. Risk assessment and other forms are available in Spanish and English. According to one non-Hispanic staff member, students are not hostile toward non-Hispanic staff, but Hispanic or bilingual staff have less trouble establishing trust with the clients. Staff are aware that many of the students are afraid to approach traditional sources of medical or social services (or are excluded from these services).

This program learned an unexpected lesson about cultural awareness in its early stages when staff realized that the badges on their health center jackets represented a neighborhood whose gang was a rival of the gang in the neighborhood where the school clinic is located. Staff have become more aware of these subtleties and now wear gang-neutral clothing. In addition, some of the school clinic's patients are gay or lesbian, so staff must be sensitive to their concerns.

Implementation Issues, Barriers, and Solutions

Family planning services. Perhaps because the need is more obvious among homeless teenagers and because parents are less involved in their schooling, restrictions on family planning activities have not yet become an issue for the health program at the alternative school. This issue has presented problems for the medical team as it works to establish links with other schools, however.

Fragmented social services and funding. Clinic staff cite the following example of their frustration: The state's Children's Health and Disability Program (CHDP) will pay only for the discovery of an adolescent's STD—not for treatment. If staff want to treat the student on the same day, they have to register the adolescent with the Office of Family Planning, which has programs to cover the needed services. Then, if they also want to vaccinate the patient for Hepatitis B, they must fill out five separate forms for a third funding source—because neither of the other two programs will pay for it. Staff say they must be very aware of their funding streams and able to work them efficiently—for example, conducting extra-thorough CHDP screenings to be sure that they discover all problems that the funding stream might cover.

Informality of arrangements. The arrangement between the health center, the medical team, the school system, and the school is entirely informal. This has both advantages and disadvantages, sources said. Without a formal agreement, clinic staff are not bound by the restrictions on providing contraceptives or family planning services that exist in the mainstream schools and have greater freedom to focus on providing the services they want to provide. However, if the school or school administration decided to end the health linkage, health staff would have no legal recourse.

Accountability and Assessment

The medical director reviews the work of other clinic staff and frequently is on site to supervise services. Because the program has been informally operated and managed, staff have not tracked service statistics very closely, although the new program manager is expected to formalize this process. The program did increase its focus on measurable outcomes after a site visit from the Healthy Tomorrows review team. Staff developed measures, based on the Healthy People 2000 objectives, such as: "When there is a positive TB test, what percentage of patients complete the treatment; is this percentage increasing or decreasing?" and "Is there an increase in the number of patients receiving repeat services?" However, medical staff and administrators are frustrated that as they begin to collect these data the disease rates appear to climb—simply because they have identified more cases—and this higher rate of sickness reflects badly on their efforts. Project leaders would prefer to assess their efforts through in-depth studies that track patients over time, but this approach requires more case management than the program can provide.

Impacts

This program has not identified many quantified impacts. However, school staff say the medical services make an important difference in the lives of many students; teachers appreciate the fact that they can obtain immediate, walk-in health service for their students simply by calling the MHOT staff. County education officials view the school-health linkage as part of broader education reform; as one source said, "You can't wait for homeless kids to come in to school—you have to have services to attract them." The school is always busy and well-attended on the day that the clinic operates because students know services will be available and because they trust the providers.

The program reports many examples of anecdotal evidence of success, including the following:

> *A 16-year-old girl who spent four years living on the streets in Mexico and San Diego after being raped by her father and his friends was brought to The Place by the clinic's outreach worker. The girl's risk behaviors included unprotected sexual intercourse, prostitution, and substance abuse as well as an illegal abortion in Mexico; she had never seen a medical provider, received a pelvic exam or treatment for an STD, or received contraceptives or counseling. When the girl arrived at the school clinic, she had severe abdominal pain. After conducting a pelvic exam and skin test for tuberculosis, screening for STDs, and giving immunizations, clinic staff held a case management meeting to find housing and substance abuse treatment for the girl. This patient enrolled in school at The Place and received follow-up visits at the clinic, where she reported that she has remained substance free and is not engaging in high-risk sexual behaviors.*

Multnomah County Health Department and Jefferson High School

Portland, Oregon

- **A range of health services improve school attendance and reduce teen pregnancy**
- **Leadership by the county health department gives the program clout and improves referrals to other services**
- **Community controversy forced program leaders and staff to develop community outreach skills**

Overview

The Multnomah County Health Department operates comprehensive, school-based health clinics in seven Portland-area high schools, two middle schools, and one elementary school. The first clinic, in a high school, opened in 1986 as an effort to reduce teen pregnancy. Today, the centers provide a range of services and use their close relationship with the health department to make referrals to interagency or outside service providers. The clinic at Jefferson High School, which opened in 1987, promotes collaboration with the school nurse and with teachers through joint classroom presentations and health curricula.

Number of students served: 4,400 students a year at all school-based clinics; 650 at Jefferson
Grades served: 9-12
Racial/ethnic breakdown: 48% African American, 31% Anglo, 8% Hispanic, 7% Asian American, 1% Native American
Eligible for free or reduced-price meals: 33%
Major source of funding: County and state funds; third-party reimbursement

School and Community Context

Multnomah County is an urban area with about 600,000 residents. The county seat, and the site of most of the school-based clinics, is Portland. Many of the clinics are located in inner-city schools surrounded by high unemployment, crime, and gang activity. At Jefferson High School, one-third of the 1,100 students are uninsured. There are other health facilities in the area, but the hospitals are too expensive for Jefferson's families and a community clinic run by a sole nurse practitioner is overwhelmed by the demand for services.

All enrolled students are eligible for clinic services, and more than half of the students in schools with clinics obtain services at least once a year. At Jefferson, 65 percent of clinic users are female; equal numbers of ninth and tenth graders use the clinic (28 percent of total visits each), followed by equal numbers of eleventh and twelfth graders (23 percent). The school population is 69 percent minority (African American, Hispanic, and Asian). Seventy percent of the clinic's users are minorities. The most frequent health needs are for acute care; reproductive health care (testing for sexually transmitted infections or pregnancy, birth control exams, and prescriptions); mental health counseling; physical exams, immunizations, or nutrition counseling; and chronic illness care.

Major Program Features

This program features autonomous, site-based management backed by strong support and coordination by the county health department,

and comprehensive health services with a growing emphasis on preventive care and education.

Planning Process

The ten-month planning period for the first school-based clinic began in 1985 under the guidance of the director of the county health department, who had received information on an early school-based clinic located in St. Paul, Minnesota from the Robert Wood Johnson Foundation. The director asked a staff person in the maternal and child health department to investigate. A few months later, when several health department staff members went to St. Paul for a conference, they toured the school-based clinic.

Other early planners included a member of the National Conference of Jewish Women who was lobbying the state legislature for programs for pregnant or parenting teens. This person and health department staff built support for the concept of school clinics among the county commissioners, one of whom was a former state legislator who helped build support at the state level. The commissioners quickly approved a proposal for a school-based clinic. Backed by the commission's promise of funding, health department staff suggested to the superintendent of schools that the clinics could improve adolescent access to health care and address the county's high teen pregnancy rate. The superintendent supported the idea and appointed a liaison to the health department.

After conducting community assessments based on incomes, pregnancy and school dropout rates, and availability of medical services, the planners targeted one school for the first clinic. The school district liaison met with the principal, vice principals, and health department staff to discuss the clinic; the principal was not enthusiastic but agreed to support the project. Together, health department and school staff decided to locate the clinic in an old kitchen that was being used for storage. The school paid to renovate the space and the health department paid for and installed equipment and clinic staff.

Planners failed to anticipate controversy over the clinic's family planning component, however. Although the principal invited health staff to speak to parent groups, it wasn't enough to address all community concerns. In response to public concern, the principal said he would open the clinic without family planning, but the health department insisted that the clinic could not open with partial services. The county commission and the school board supported the health department's position. The principal met privately with concerned parents, and clinic staff invited parents to tour the clinic and talk with staff. As the planners demonstrated their responsiveness to community concerns, and explained the purpose and scope of the program, the uproar gradually subsided.

Program Design

Jefferson's clinic offers routine and sports physical exams; diagnosis and treatment of minor illness or injury; general infection checks; routine testing for students who have a family history of diabetes or anemia; vision, dental, and blood pressure screening; diagnosis and treatment of menstrual problems and sexually transmitted infections (STIs); immunizations; HIV/AIDS prevention counseling and testing; nutrition education, weight management, and a weekly self-esteem program for girls; counseling for smoking cessation; mental health counseling, including a five-week classroom course on depression; substance abuse support services; a peer trust group for boys; individual counseling on family planning; reproductive exams and birth control prescriptions; condom distribution; and referrals to other health and social service providers.

Because a primary focus of the program is pregnancy prevention, clinic staff at Jefferson locate clients by having all high school students

who use the clinic fill out a medical history designed by the county health department. Students whose responses show them to be at high risk of pregnancy receive individual counseling on family planning. The clinic does not provide referrals or counseling for abortion but does connect students with prenatal programs. The clinic coordinator monitors pregnant students to make sure they receive full health care, keep their WIC appointments, participate in the school's teen parent program, and meet with a field nurse to arrange home visits.

Referrals. If students submit a signed release form, the clinic will send medical records to a family doctor. The nurse practitioners work hard to link with family doctors, make referrals to surgeons, negotiate price breaks or payment schedules with hospitals, or help students apply for Medicaid status. In many cases, clinic staff found that students with private insurance preferred to get services at the school-based clinic because they didn't have to schedule appointments as far in advance—and were therefore likelier to keep their appointments. The Jefferson clinic refers about 25 percent of students to medical specialists, 25 percent to drug or alcohol abuse programs, 75 percent for dental care, and 50 percent for counseling or therapy.

Parental consent. The school-based clinics' medical and mental health protocols follow state law, which says that parental consent is not required for students at least 15 years old to receive medical services. State law permits children or youth of any age to obtain family planning and STI services, and children at least 14 years old to obtain mental health care, without parental consent. (However, the mental health department's protocols require parental consent for psychotropic or antidepressant drugs, even for children who can legally consent to health services. School-based clinics follow the more stringent mental health policy.)

Students under age 15 usually must have parental consent for services administered by the school-based health centers. Clinic staff ask all students who visit the clinic to sign a consent card that gives the clinic permission to diagnose and treat the student. Parents must also sign the card if the student is 14 years old or younger and the health care is not related to reproductive health. The consent card also requests permission for clinic staff to share information with the school nurse. Students who are not required to have parental consent are still encouraged by clinic staff to involve their parent or guardian in their health care, whenever possible.

Integration and coordination of health and education programs. Clinic staff make many classroom presentations on topics including stress, hypertension, and STIs. The mental health worker and the nurse practitioner implemented a five-week curriculum on depression, developed by Oregon Health Sciences University, in a combined health and English class. The clinic offers a selection of presentations but waits for teachers to request specific services. Clinic staff also attend faculty meetings to raise awareness of the health services.

Jefferson's clinic is not well connected to the school's curriculum design efforts but is trying to improve this. The school's vice principal in charge of curriculum serves on the clinic's advisory board. Recently, the school's health teacher raised the issue that the school does not teach health until sophomore year, yet many risk behaviors begin during freshman year. Clinic staff and the health teacher took advantage of the vice principal's participation on the advisory board to ask for a curriculum change. Clinic staff also are collaborating with classroom teachers in developing a new, interdisciplinary health sciences/biotechnology magnet program in conjunction with local hospitals and a health sciences university. In addition, the principal or vice principal teaches a special class for students

who show leadership potential. The clinic's lead nurse uses this class to get students involved in the clinic by planning special health-related events.

Jefferson's clinic coordinator meets every two weeks with a school liaison; before interacting with outside agencies, the coordinator talks with the principal first. Jefferson's part-time school nurse has daily contact with the clinic by phone or in person. Clinic staff rely on the school nurse to advise students and to assess the immediacy of students' needs. The clinic provides the school nurse with appointment times at the clinic for students needing further assessment, diagnosis, and treatment. Other referrals come from counseling staff, teachers, and other students.

Organizational/Management Structure

Each school-based clinic has an advisory board composed of parents, teachers, students, and community members. Most groups have about 10 members and meet quarterly. Early advisors had trouble deciding whether the board should take an advisory or a governing role; it took time to sort this out. But the board proved useful in building support for the school-health linkage. A pediatrician who initially thought he would lose business when the clinic opened realized through his membership on the board that he would actually receive referrals for services the clinics didn't provide—and that the clinics would take responsibility for children who couldn't afford a private pediatrician. Leaders now use the board to gain feedback on draft policies and procedures, to offer advice on the best way to reach parents and community members, and to solve specific problems.

At Jefferson, the vice principal in charge of student support services sits on the clinic's advisory committee. Clinic staff have a strong, informal relationship with the school principal and feel free to stop her in the hall to discuss problems in addition to meeting in a more formal setting.

Staffing

The Jefferson school-based clinic is coordinated by a community health nurse, also called a lead nurse. The staff includes a licensed practical nurse (LPN), a fulltime mental health professional, a fulltime nurse practitioner (one job shared at this school by two people; some of the other Portland clinics have a physician assistant instead), and an office assistant. The nurse practitioner provides diagnosis, treatment, and prescriptions. The LPN obtains medical histories, updates immunizations, and provides other support; she is supervised by a nurse or nurse practitioner. The clinic coordinator has been at Jefferson since 1990 and has worked in various county health departments since 1978; her specialties are primary care, family planning, and prenatal care. The LPN has worked in a primary care clinic and pediatric mental health facilities. One nurse practitioner spent many years in pediatrics, following work as a registered nurse; she also worked in a health maintenance organization and a county health department. The other nurse practitioner is a new graduate with experience in critical care; she is a family nurse practitioner who worked on call at Jefferson's clinic before being hired.

The community health nurse's role is to coordinate the program, provide health education, assess students' health-related needs, facilitate meetings, disseminate information, follow up on referrals, and co-supervise the LPN. The community health nurse does not supervise the nurse practitioner. A lead nurse practitioner from the county health department visits all clinics and evaluates staff. Jefferson's coordinator visits other clinics to observe and provide feedback on professional skills and competencies, and their staff do the same for her.

In addition to training in how to work with the media to provide information to the community that will help reduce concerns, clinic staff receive training and travel funds for professional

development from the county. Once a month, for three hours, they participate in a meeting of all school-based project staff that focuses on information sharing and education. They also attend an educational forum; a recent one focused on domestic violence. Clinic staff also can apply to the county for development-related travel or training; all of the providers at Jefferson participate in this at least once a year.

Funding and Reimbursement

In fiscal year 1994-95, the budget for Multnomah County's 7 high school clinics (and clinics in two middle schools and one elementary school that were scheduled to open during the year) was $2.2 million. Revenues come from county general funds ($1.4 million), federal funds ($270,000), the state health division ($110,000), and insurance and other reimbursements ($140,000). The program does not charge fees to patients. The schools contribute space for the centers and pay for utilities and janitorial service. The health department and county funds pay for the clinic staff and services. The average cost per student and the cost per type of service are not available. The program has been able to secure stable, sufficient funding because of its popularity with the county commission and its now successful relationship with the community.

The primary community resources used by the clinics are referrals for other services, especially housing, food, and transportation. The community health nurses located at each clinic are knowledgeable about community social services, and the fact that school-health linkage is run by the county health department gives the program quick access to STI and tuberculosis clinics or field nurses who make home visits.

The clinics serve a relatively small number of students who belong to HMOs, although program leaders say it is hard to collect reliable data because students don't always know their status and schools don't keep good records. The health department itself is a managed care organization, however, and can bill Medicaid for traditional public health services provided to students who belong to managed care organizations. The school clinics cannot recover costs for general primary care, such as treatment of illness or injury or sports physicals. The health department is responsible for billing Medicaid and insurers. Staff will not bill for reimbursement if it would jeopardize a student's confidentiality.

Family and Community Involvement

Organizers of Portland's school-based clinics learned from the experience of the first clinic that schools often are not prepared to communicate effectively with the public and address community concerns. For subsequent clinics, organizers met publicly with parents, county commissioners, and school administrators to air concerns. Now, staff involve parents primarily through participation in the advisory committee and by sending representatives to the back-to-school nights. Family members do not receive care from the clinics unless mental health treatment requires their participation. Clinic staff refer students' parents and siblings to other primary care clinics when requested but do not treat them on site. Many factors are involved in this policy, including clinic capacity, confidentiality, and school rules regarding the presence of non-students on campus.

Following state laws on parent notification for children of high school age, Jefferson clinic staff contact parents only if they have the student's consent; in these cases, they use the opportunity to initiate a relationship by telling the parents how their children are doing. (Children under age 15 require parental consent for most health services in Oregon.) Clinic staff have developed a packet for parents that provides information on services, and they are surveying parents to see how useful it is. Clinic staff also attend parent/teacher nights three or four times a year to distribute health information pamphlets

and to answer parents' questions about the clinic. The clinic coordinator has used the school newspaper to build support by inviting student reporters to interview clinic staff about special events, such as AIDS Awareness Day or pregnancy prevention month. The clinic includes health information and clinic schedules in a parent newsletter published every other month. The school-based clinics also gain parents' approval by diagnosing, prescribing, and obtaining medications for minor problems such as earaches within the timespan of one school day, eliminating the need for parents to take time off from work to visit doctors and pharmacies.

Implementation Issues, Barriers, and Solutions

Support from the school principal, and coordination with the school district, are crucial to responding to community concerns. Principals must take ultimate responsibility for displacing other staff to make room for the clinic and responding to community concerns. No matter how carefully a community health center and school collaborate, parents and community members tend to see the school-health linkage as a school activity; they will share their concerns with the principal and school district long before they will complain to the health department. "You may be sitting here thinking everything is hunky-dory because you're not getting the phone calls," advised a program manager. Health centers that operate school-health linkages must have close contact with the school district's public information officer or media contact so the health and education partners can speak with a unified voice.

Myriad school health regulations overburden schools and can diminish their effort to provide basic health services. There are so many laws governing services for special-needs or disadvantaged students, says one health administrator, that they have had a backfiring effect. Schools are struggling to meet multiple requirements with limited funding and staff time, and the provision of basic health services sometimes falls through the cracks.

Accountability and Assessment

The clinics keep a written record of every visit made to every center, coded by diagnosis and including demographic data. The findings are included in the program's annual report. These records also provide baseline information on why students use the centers, to help with program planning and needs assessment. For example, after the clinics' first year, records of visits showed a strong need for mental health counseling, so a part-time counselor was added to the staff; when records of waiting lists and student demand showed a growing need for these services, the mental health staff became full-time. The data allow the clinics to plot changes in student-staff ratios, anticipate needs for future sites, and respond to questions from the public regarding clinic use.

Surveys of students, parents, and school staff collect information on client satisfaction and measure the extent to which the program has filled the gap between unmet needs and services. Results show that the centers' users are the highest risk categories of students; their presence in the clinic confirms that the targeted clients are using the center and finding its services acceptable. Over time, clinic staff hope the records will show a reduction in risk behaviors.

In 1994, the program began gathering data for an evaluation that includes surveys of parents, students, and school personnel using instruments designed by a professional researcher. Planners hope to repeat the evaluation every two years but are concerned about the costs associated with surveys and the number of different surveys that schools must administer.

Impacts

The health department is planning a baseline survey of utilization patterns and health concerns that will include a survey to determine what parents want or need from the health center. Planners envision the survey as a way to involve parents and communicate their concerns to the schools.

Attendance at Jefferson has improved since the clinic began, from about 60 percent to 75-80 percent. The school has avoided suspending or expelling troubled students by enabling them to obtain mental health services at the clinic while they continue to attend school; the principal credits the health linkage with reducing the dropout rate and encouraging former students to re-enroll, but no data are available to support this. The principal views clinic staff as a helpful resource for teachers because the clinic provides services that "keep kids plugged in academically." She also notes that the clinic has been vital in providing the first diagnosis of students with serious respiratory conditions or hypertension.

Southeast Lancaster Health Services and King Elementary School

Lancaster, Pennsylvania

- **Close collaboration between the school nurse and clinic staff makes services more efficient and builds credibility among school staff and parents**
- **Links between the school and a family center eased the way for the school-health linkage**
- **Proximity of the school, community health center, and a family center to one another encourages coordination of services**

Overview

The goals of this school-based program are to reduce student absenteeism, minimize the interruption of education for health reasons, and increase students' access to health services. The clinic at King Elementary School is one of six state-initiated pilot sites and one of two school-health linkages administered by the community health center. School sources view the program as a means of expanding services offered by the school nurse; the health center views it as a way to serve clients more effectively.

Number of students served: Between 400 and 600 per year at King; in 1993, there were 864 student visits to King's clinic. Enrollment at King is 770.
Grades served: preK-6
Racial/ethnic breakdown: 66% Hispanic, 28% African American, 5% Anglo, 1% Asian
Eligible for public assistance: 90% eligible for free or reduced-price lunch
Major sources of funding: State and federal block grants and Medicaid reimbursement

School and Community Context

Lancaster is a compact, urban area 65 miles west of Philadelphia. The city has 11,000 students, of whom 60 percent belong to racial or ethnic minorities. Southeast Lancaster has a large population of low-income families; between 80 percent and 85 percent of the students are eligible for federal medical assistance, yet except for the health center, few private physicians accept patients on medical assistance. Every school in Lancaster has a school nurse, and the district's three school-based health centers are located in the school nurses' offices. Southeast Lancaster Health Services operates two school-based health centers: one at King, located one block from the community health center, and one at an elementary school nearby.

King is located in the poorest section of Lancaster, where 25 percent of the residents are unemployed—three times the percentage city-wide. The school has a schoolwide Title I program in its third year of implementation. The neighborhood has large Hispanic and African American populations; 11 percent of the school's students are in bilingual education and 11 percent take English as a Second Language. Most students are uninsured. The major health needs are treatment for conjunctivitis; sore throats or upper respiratory infections; headaches; vomiting; or acute trauma such as bruises, scrapes, or strains—conditions that are typical of students throughout the service area.

Major Program Features

The school-based clinic at King keeps limited hours, uses minimal equipment, and provides basic health services—but careful coordination with the school nurse, the health center, and a school-affiliated family center enable clinic staff to serve most health needs as they arise. The program builds support by seeking collaboration with these other entities, maintaining open communication with parents, avoiding controversial services such as family planning, and proving that clinic services keep children in school.

Planning Process

The year-long planning process for the school-based health centers began in late 1992. Planners obtained a grant in 1993 and opened services at King at the beginning of the 1993-94 school year. The second site opened in 1994. There was no prior school health program beyond school nurses. The location of health services at the elementary level represents a planning compromise. When school officials and health care providers first discussed linking health services with a junior high school, controversy over family planning in the politically conservative community forced them to abandon the idea. Later planners avoided the controversy by focusing their efforts at the elementary level.

The impetus for the school-based health linkage was a state initiative, through the department of maternal and child health, that funded six pilot school health programs. Sources say that because the program began with a state grant, the community supported the effort. Health center staff also had close, longstanding friendships with key district administrators and school staff. In fact, the health center's director views the recent school-health linkage as simply formalizing an arrangement that has existed for many years, in which school health staff referred students to the health center for treatment. Making this informal relationship contractual was not a significant change.

The planning committee included representatives from the state departments of education and welfare, medical providers and practitioners, school district administrators, principals, school nurses, and community members. This large committee first identified principals who were willing to accept a clinic and then located agencies that were interested in providing services. The committee collected information on school linkages from other health centers in the state, consulted with state education officials, and visited other sites in the state to determine which models would best respond to local needs.

As the committee moved toward implementation, it broke into smaller groups to address such issues as staffing, equipment, hours and protocols for operations, facility design, and budgets. An advisory committee with 10 to 15 members, including the school district's physician-advisor, the head school nurse, a principal, school district administrators, hospital and health center staff, community members, and representatives of community agencies—met every two or three months to discuss issues, formulate strategies, and oversee the budget. The original planning group became a permanent integrated services consortium, a trouble-shooting mechanism for the school clinics. Now, the principal says, "when we run into a barrier, we kick it up to the consortium and tell them to get rid of it."

Program Design

The program provides outpatient medical services during four, two-hour sessions per week at each school during the morning or afternoon. The clinic serves about 10 students a day. A family practice physician and a physician assistant visit the school-based clinics, where they collaborate with the school nurse. The health center provides a billing clerk, who maintains student health records, and the school district provides the school nurse. School counselors also work in the school clinic.

Services include acute care; chronic care, mostly for asthma, Attention Deficit Disorder (ADD), or diabetes; ADD evaluations; EPSDT screenings; immunizations; health education; counseling on health issues; and classroom observation of students with behavioral problems. Clinic staff write prescriptions but do not dispense medications, although if medications are needed to keep a child in school the clinic arranges for a pharmacy to deliver the first dosage to the clinic. The decision not to dispense medications regularly was a response to school board concerns about liability.

Because the school district does not want to pay for the school-based clinics, the schools contribute only the school nurses' salary, some of the principal's time for coordinating the services, use of the clinic space, and access to school administrative equipment; grants support the actual services. The clinic receives some support from a family center located 50 yards from the school. This center coordinates social services for students' families, including networking with service providers, one-stop shopping for mental health care, transportation, case management, job training for parents, and counseling. The school clinic and the family center began operating at the same time but the family center was preceded by three years of planning. Many of the issues that typically pose barriers for school clinics were addressed first by the family center. The family center also helped attract funding because it offered a way to combine efforts.

Referrals. Referrals come from teachers, parents, or the principal. The school nurse assesses medical priorities among all students seeking care. Acutely ill students or those who need treatment when the clinic is closed are referred to the health center or the hospital emergency room; when appropriate, the school nurse may call the health center and receive instructions from the physician via telephone. An estimated 15 percent of students who use the clinic are heavy users. Many of these students have asthma or simply report feeling pain frequently.

The clinic has not established a system to track the number of referrals to outside providers, but staff say at least 90 percent of the students' needs can be met in the clinic. Most outside referrals are for ear/nose/throat tubes, behavioral or family counseling, surgery, or acute emergency care. Some clinics and private practices in the community accept a limited number of uninsured students. When clinic staff must coordinate services with a student's family physician, the clinic physician calls the family doctor directly and asks permission to observe the child and confer about the observations. Cooperation has not been difficult; some family doctors ask the clinic physician to prescribe treatment.

Consent. Parents give consent by "enrolling" their children in the school clinic. At the beginning of each year, the school distributes enrollment forms that require the parent's signature and identify the child's primary provider and preferred pharmacy. Enrollment must be renewed annually.

Integration and coordination of health and education programs. The school system, clinic staff, and school nurse view the school clinics as very well integrated with the education program—"part of the continuum of services available" in the school. When the clinic first opened, staff held an orientation for all school staff and teachers so they would understand the clinic's role. At the teachers' request, clinic staff periodically give presentations on health issues, such as nutrition or sexually transmitted diseases (STDs), to parents who participate in a diploma equivalency class at the school. The nurse and physician visit students' classrooms if a teacher requests a presentation. Clinic staff provide group education on immunizations for parents of preschoolers. Sometimes, teachers bring groups

of students or an entire class to the school clinic for a special project or when students are studying a health unit in the curriculum.

Organizational/Management Structure

The key managers of this school-health linkage include the district's coordinators of pupil services and health services, principals, the district's business director, school nurses, the program's medical director, the clinic physician, and physician assistants. At the schools, the health center's medical director oversees the program and supervises the physician and physician assistant (at King, the medical director and the physician are the same person). The health center's director handles billing, contract negotiations, and longterm decision making. There is no advisory committee, but King, which also has a family center, has a coordinating committee to which clinic staff belong. This committee involves teachers from all disciplines, the school nurse, family center staff, the principal, guidance counselors, and the school psychologist; it provides a mechanism for coordinating services for students with special problems. The council meets at least once a week.

The health center's director characterizes his program's relationship with the district as "very informal." About once every two months, the school district convenes a meeting of program staff and directors, educators, health providers, and other community members interested in school health care. A recent meeting focused on the county's decision to shift to mandatory managed care and how schools can provide services for students whose primary care physicians are not on-site; a follow-up meeting will allow service providers to talk directly with representatives of managed care groups and district administrators. Other meetings have focused on enrollment or billing issues.

Staffing

The school nurse works full time at the clinic and remains at the school even when the clinic is closed. She is joined during clinic hours by the physician, who works at the clinic one day a week, or the physician assistant, who spends three days a week at the clinic. The physician is also the health center's medical director. The school nurse plays a crucial role in the school-health linkage and has full responsibility for processing referrals. Before the student sees the physician or physician assistant, the school nurse measures the student's height, weight, blood pressure, and temperature; gathers a brief history of the illness; and may contact the referring teacher or parent. The physician or physician assistant examines students and writes prescriptions. The school nurse may then administer the treatment or contact the student's parents or family doctor. The physician supervises the physician assistant, reviewing his notes and diagnoses, but does not consider herself responsible for supervising the school nurse, who has a great deal of autonomy.

King's principal, not a strong supporter of the clinic in its early stages, now says that the staff is so well integrated into the school that it's hard to distinguish health center staff from school staff within the clinic. Some observers credit the principal's growing support to the fact that the clinic has increased parent involvement in their children's problems, created a professional medical atmosphere, and proven that clinic staff are willing to operate as part of the school team—not by forcing changes. The school nurse's acceptance of the clinic also helped bring the principal and teachers on board.

Funding and Reimbursement

In 1995-96, the budget for Lancaster's three school-based health centers will be $123,000, of which federal and state block grants will pay $66,000 and $57,000 will come from medical assistance reimbursements or hospital contributions. Each of the three school clinics, including

King, receive approximately equal shares of the budget. The major operating cost is for salaries. Half of all revenue that the health center receives as a result of services to students at the school clinic (from Medicaid and private insurers) is shared with the school district. Uninsured students are served at no charge.

Longterm, sustainable funding for school-based programs is hard to find, however. State grants enable the program to provide free services, and the clinic relies on the reallocation of some school staff, general district funds, and resources from the community health center to meet the remaining expenses, but this linkage would have great difficulty surviving if it had to rely on reimbursements. The state reduced its financial commitment from 80 percent of the cost in 1993 to 65 percent in 1994, and the health center director says the program may not be able to continue if the program is forced to support itself.

The health center is responsible for billing Medicaid and private insurers. However, some managed care plans refuse to reimburse the school-based centers for services provided to their clients. The contract between the school system and the health center allows the health center to bill the school for any differences between the amount billed and the amount reimbursed, to be paid out of the grant funding. Although this has not yet been an issue, it is a potential unplanned expense. The program does not charge students for services. Program administrators are frustrated in their billing attempts by the fact that Medicaid eligibility fluctuates for many students; an estimated 15 to 20 percent of the students regularly go on and off medical assistance. The program does not track the number of students enrolled in HMOs.

Family and Community Involvement

Although the clinic serves only students and family members, clinic staff use the family center connected to the school to expand their outreach to families. If the clinic needs to provide services to a child who is not enrolled and whose parents cannot be reached by phone, staff from the family center will find the parent and schedule a conference to explain the clinic's services. Clinic staff attend parent-teacher association meetings, and the health program has informal relationships with several community organizations and institutions. A hospital contributes a nurse to the clinic five days a week. The health center contracts with the Boys and Girls Club next door to provide acute care and physical exams for clients at a shelter for abused children, and clinic staff provide education on STDs, hygiene, and dental care for staff and shelter residents. Members of the Urban League and other community groups belong to the board of directors for the school clinic, and vice versa, which increases understanding and investment among the programs.

Staff say the school clinic's close ties to the community health center are crucial to building community support, because the health center is already a trusted and familiar institution. "We're already part of the community; we're not imposing anybody from outside," says one physician. "A lot of the students and parents [at the school clinic] I already know....I would not want to run the health clinic across town from us. I do not think it would have the same success."

Implementation Issues, Barriers, and Solutions

Misunderstandings can limit parent participation and continuity of services. There is not yet any continuity in school-health services between the elementary and middle school levels, although clinic staff and administrators see this as inevitable as parents get used to the clinic's basic services, learn to trust the staff, and shift their focus from concerns about birth control to awareness of other services. Staff have had trouble getting parents to understand two issues: (1) Use of the program is voluntary, not mandatory,

and (2) parental consent must be given every year. At King, student enrollment in the health program was lower than expected at the beginning of the second year because some parents thought the permission slips they signed the previous year were permanent. To increase awareness, clinic staff attend parent conferences and PTA meetings and the school nurse sends materials home with students.

State administrative bureaucracy can undermine reimbursement efforts. It took six months for the school-based site to get approval from the state as an EPSDT provider, which would enable the program to collect reimbursement from Medicaid, although the health center was authorized and the school clinic was presented as a satellite of the health center.

Proximity of collaborators affects the success of a school-health linkage. Families whose children use the clinic are already using the health center, so clinic staff are familiar with many cases; and the short distance between the school, health center, and family center makes it easy to share resources and coordinate parents, teachers, and staff for consultations. The proximity also reduces the amount of time students spend out of class.

Accountability and Assessment

This program tracks the number of visits made to the clinic each year but does not gather data on diagnoses or treatment or on how many of the visits were medically necessary. Staff gather vital signs on each child they see, to which the doctor or physician assistant adds notes on the child's condition. One copy of each chart is kept at the clinic and one copy goes to the health center. Clinic staff expect a new computer system to facilitate more sophisticated data collection, identify diagnosis trends and patterns of use, and add more quality assurance mechanisms. Because of limited staff time, tracking data manually is almost impossible. A quality assurance system is in place for lab tests, and the physician reviews all dictations and charts done by the physician assistant.

Clinic staff measure the clinic's progress by the increasing number of students using the clinic and by growing community acceptance. "Just walking around the school is all you need to assess the program—the amount of students who know who we are, the amount of parents who send notes wanting [children] to be seen, the trust level," says one provider. State evaluators visit the program twice a year and regularly receive statistics from program administrators. Clinic staff initiated an occasional roundtable discussion with parents to elicit feedback, which they use as affirmation that the program is on track.

Impacts

The school-based clinic at King has enabled students with ringworm, impetigo, and conjunctivitis to avoid missing school by obtaining immediate treatment on-site. Without the clinic, state rules would require these students to stay out of school until they begin medical treatment. Clinic and school staff say it is too early to see some of the expected longterm outcomes, such as a reduction in teen pregnancy and STDs, but they have observed a general reduction in students' fears of doctors or the medical system, an increase in trust, and more willingness among parents to get involved in students' problems.

King's average daily attendance rate is 95 percent, and the principal attributes at least 2 percent to the existence of the school clinic. The principal says the program has also improved follow-up services and reduced the length of student absences. Teachers are reassured about having students with more serious illnesses return to class because they are confident that the student has received appropriate treatment through the clinic. The school-health linkage has also broadened collaboration between community agencies and schools.

Valley Wide Health Services and Sierra Grande School

Blanca, Colorado

- **Preventive program serves a very large, rural region that has limited access to other health care**
- **Care providers build informally on close, long-term relationships to integrate service efforts**
- **Nutrition and pregnancy counseling have increased school attendance 10 percent**

Overview

Valley Wide Health Services operates six community health centers that serve an 8,000-square mile region in rural, southern Colorado. The valley has about 40,000 residents, most of whom work but are poor, and the health centers provide about half of the communities' health care services. Valley Wide, which opened in 1976, also operates two school-based centers and ten school-linked programs with ties to the six community centers. These programs serve 3,700 students in 12 school districts. About half the programs serve grades K-12 and half serve grades 9-12.

Number of students served: 330 per year at Sierra Grande School
Grades served: K-12
Racial/ethnic breakdown: 82% Hispanic, 13% Anglo, 5% Asian American
Eligible for public assistance: 80% receive free or reduced-price lunch
Major sources of funding: Federal grants, state block grant for child health

School and Community Context

The region served by the Valley Wide center in Alamosa includes six counties, each of which has a community health center. Because the school-based clinics serve students who live a long way from the health centers—and because many families lack transportation to the larger health centers—the school-based clinics are an important front line of health care for many students.

Sierra Grande School in Blanca has a school-based clinic linked to Valley Wide's health center in Alamosa, 27 miles away. Eighty percent of the students qualify for free or reduced-price lunch. Sierra Grande serves about 330 students, most of whom are Hispanic, in grades K-12; it operates on a four-day week with extended-hour schooldays. The school's clinic, which opened in 1982, is located in a recreation center next to the school. About 25 percent of the students do not have any health insurance, and more than 50 percent are eligible for Medicaid.

Major Program Features

Valley Wide's school-based services focus on enhancing access to health care, making adolescents more likely to use overall preventive health care measures, and reducing teen pregnancy. The clinic emphasizes health education for youth between the ages of 12 and 19—individually and through classroom instruction—and case management of adolescents.

Planning Process

Valley Wide became involved in school-based clinics in 1978, when teachers at a school where half of the girls in the junior class were pregnant came to the health center for guidance. A physician and the director of Valley Wide approached the school superintendent and offered to provide health services at the school, including reproductive counseling. A Valley Wide nurse practitioner began visiting the school once a week to talk about birth control. Students also came to the clinic to discuss health concerns such as depression, acne, self-esteem issues, and family problems. Valley Wide did not form a planning committee or review other school-health linkages before establishing its first school-based clinic.

Valley Wide cites several reasons for the school clinic's initial success. First, the health center's physician was a well-respected member of the community; people trusted his opinions and did not challenge him. Second, the community recognized the teen pregnancy problem, and most people wanted to do whatever was needed to reduce teen pregnancy. Third, the community health center was well established in the community, which gave the school-health linkage legitimacy. Fourth, Valley Wide respected the community's need for discretion about sensitive issues; when the pregnancy prevention component drew media attention, health staff worked to protect their clients' privacy.

The school-health linkage expanded to Sierra Grande in 1982. The program was initiated simultaneously by school officials concerned about teen pregnancy and lack of student access to health information or services, and by Valley Wide organizers who sought to expand their services. The school superintendent, whose son was the community center's director, served on the center's advisory committee and recognized that the community—especially children and adolescents—needed better access to health care. The advisory committee for the community center conducted a community needs assessment and found parents to be extremely supportive of counseling or educational services involving sex education, nutrition, eating disorders, and self-esteem. Valley Wide's director of adolescent health made a formal presentation to the school board, which approved a clinic for Sierra Grande students at the community center once a week.

Program Design

Valley Wide has formal agreements with 12 of the valley's 14 school districts to provide health education. At schools where the program is school-linked, students are referred to the Valley Wide health center in their community. In the school-based clinics, including Sierra Grande, services include physicals, Pap smears, STD screening, acute care, throat cultures, and health education. Valley Wide follows school policy on reproductive counseling and family planning; some schools allow only abstinence counseling. However, some health center staff refuse to talk about AIDS in schools that prohibit them from mentioning contraceptive devices because of the role condoms can play in preventing the disease from spreading. Valley Wide provides medical services to students while the schools provide space for school-based clinics, make referrals, and provide equipment.

At Sierra Grande, the clinic operates on Tuesdays from 9 a.m. to 3 or 3:30 p.m.; normal school hours are from 8 a.m. to 4 p.m. The clinic provides primary health care; physical exams; screenings; family planning services; STD testing; a wellness program for pregnant teens; mental health referrals to counselors at a mental health center for students with suicidal tendencies, self-esteem issues, or drug abuse; and nutrition counseling in classroom settings.

When a student enters the clinic, he or she receives a risk assessment that covers drug or alcohol use by the student and parents, sexual and physical abuse, academic difficulties, family

problems, suicidal tendencies, and use of preventive measures such as dental care, exercise, and seatbelts. Clinic staff try to see every ninth-grader at least once during the year to assess their health, provide individualized education on health services, and establish rapport. Most students visit the health center about five times a year; although there is no specific target population, the program attracts high-risk students.

Referrals. Clinic staff meet with teachers and school administrators as needed to refer students to the clinic. Clinic staff often observe students in class to identify conditions such as Attention Deficit Disorder. About half of the Sierra Grande students who use the clinic are self-referred. A physician assistant from Valley Wide sees all new students to conduct a health screening and to give the students a trustworthy point of contact with the clinic. The physician assistant at the clinic gives a list of appointment slots to the principal's secretary one week in advance, and the secretary fills in the names of students referred by teachers and filtered through the school counselor.

Students who require more comprehensive health services such as X-rays are referred to the community health center or to their primary care provider. Federal public health grants cover comprehensive services for adolescents who do not have health insurance and are ineligible for Medicaid. Students are referred to the county mental health center for drug abuse treatment and other mental health needs; a Valley Wide representative often accompanies students on their first visit to the mental health center. Other providers in the community are cooperative in accepting referrals from the school clinic and sending medical records to the clinic, although there is no formal system in place.

Parental consent. State law requires parental consent for mental health services for children under age 15 but not for other services provided by the school-based clinic. Valley Wide uses parental consent forms at some schools but not at Sierra Grande, where staff decided not to use the forms because they did not want to deny access to any students. Clinic staff strongly encourage students to discuss their health needs with their parents, however.

Clinic staff and the school principal emphasize confidentiality, especially regarding reproductive services, in order to encourage students to use the clinic. State law prohibits health care providers from informing parents of a child's use of drugs or birth control, STDs, or pregnancy, unless the child consents or there is a medical emergency. Confidentiality has not been a major problem at this site.

Integration and coordination of health and education programs. Valley Wide provides a significant amount of health education in classrooms. The school's health educator and the clinic's physician assistant often make joint classroom presentations on issues such as sexuality, drugs and alcohol, and self-esteem. Clinic staff make these presentations to high school physical education classes once a week for nine weeks and to elementary school classes when requested by a teacher.

Organizational/Management Structure

The director of Valley Wide's Adolescent Health Center oversees the school-linked and school-based health centers. At Sierra Grande, which receives health services one day a week, the program is managed on site by a physician assistant and an adolescent health educator provided by Valley Wide. The program director visits the school-based health center frequently to supervise staff. He also reviews the records of services provided to students each week. The principal at each school monitors clinic staff to ensure that they follow school policies. Valley Wide has a formal agreement with Sierra Grande to provide health services, but there is no formal mechanism for meeting with school

administrators and there is no advisory committee. Meetings between clinic and school staff occur informally. Valley Wide also has an informal agreement with the county mental health center to provide counseling and substance abuse treatment, and with the Department of Social Services, which accepts referrals of troubled students.

Staffing

Sierra Grande's clinic is staffed by one physician assistant and one adolescent health educator, who are supervised by the director of the adolescent health center. The physician assistant has a master's degree in pediatric and adolescent health; she also serves on the Alamosa School Board, giving her longevity, credibility within the school and education communities, and access to education as well as health perspectives. Clinic staff regularly attend seminars and conferences related to adolescent health.

Sierra Grande had a school nurse until 1992, when funding was cut. The school nurse was an early proponent of the linkage with the school-based clinic and was the primary source of referrals to the clinic. A school counselor now refers students to the clinic but does not have a strong relationship with clinic staff; the principal attributes this to time pressures rather than turf issues.

Funding and Reimbursement

Valley Wide's clinic at Sierra Grande School costs approximately $15,000 to $20,000 per year. The project receives approximately 90 percent of its funding from federal public health grants and 10 percent from a state block grant for child health. The clinics charge sliding fees but do not refuse services to students who cannot pay. When the project began, the clinics did not bill Medicaid for reimbursement because (1) it would require them to pursue payment from families first and most families are too poor to pay, and it would require the health centers to pursue payments from third-party insurers, creating paperwork and time burdens. In 1994, however, Valley Wide began billing Medicaid for reimbursement. Although clinic staff find it very difficult to collect the required information on Medicaid eligibility and insurance coverage from students, the project does receive reimbursements from approximately 90 percent of claims that are filed.

Family and Community Involvement

Sierra Grande's clinic is located in a community center across from the school, but it primarily serves students. Although the clinic targets adolescents, and family members do not use the school-based clinic, staff will treat any patient who comes into the clinic. Valley Wide hopes to expand clinic hours at Sierra Grande and serve more community members within the next two years.

Parents have been very supportive of the school-based clinic. "For every parental complaint I get, I get 30 or 40 calls of praise," the principal says. Community outreach and coordination of services has been made easier by the fact that in Sierra Grande's small, tight-knit community many parents, teachers, and clinic staff know or are even related to each other; the same people often serve on the governing boards of mental health or social service organizations, juvenile justice institutions, and community groups. The clinic also builds support by including information about health programs in weekly mailings to parents that contain the school lunch schedule, and by sending home letters that explain specific health issues. Clinic staff call parents to inform them of health issues. Whenever a controversial issue arises, the school holds small-group meetings or hosts a neighborhood block party to bring in community members to discuss their views.

Implementation Issues, Barriers, and Solutions

The clinic's hours of operation are limited. Health services often are needed on the three other days of the week when the school is open

but the clinic is not. The principal says that if he were starting again, he would find a way to have the health provider on-site for half of each week instead of one day a week, to take advantage of informal referrals and to be more responsive to ferreting out students' less-obvious health needs.

The referral process limits teachers' direct involvement with clinic staff. Because the school's 28 teachers make referrals to the school counselor or the principal's secretary, who schedules the appointments for the physician assistant, there is no formal process for letting teachers speak directly with the physician assistant. Because of the community's close ties, however, this has not posed a problem for Sierra Grande's clinic. Valley Wide staff are easily accessible by telephone, and teachers regularly speak with the physician assistant on an informal basis.

Long-term funding is hard to sustain. Grants from private foundations often are exhausted in a short time. The revenue collected by the school-based clinics and the community health centers is insufficient.

Teachers sometimes complain about students missing class. Clinic staff try to see all students at least once during the academic year. Some teachers complain that students miss too much class time visiting the health center. Valley Wide has tried to solve this problem by scheduling clinic visits during various times of day so students do not always miss the same class. Teachers can ask students to reschedule clinic appointments if they think the student should not miss a particular class.

Accountability and Assessment

Valley Wide's director of adolescent health monitors the program by reviewing a monthly, computerized update of daily services that indicates the number of students served. The health center conducts a yearly performance review of clinic staff to ensure quality. Valley Wide also surveys students twice a year to identify why they use the clinic and to evaluate service quality. Survey data are reported to funding sources and are used for program planning.

Impacts

When the clinic at Sierra Grande opened, the school's attendance rate was approximately 70 percent; in 1992-93, it was 94 percent. The principal attributes at least 10 percent of this change to the health services provided by the clinic, including nutrition and pregnancy counseling. Since the school-based clinic opened, the teen pregnancy rate at Sierra Grande has sunk from 8 percent to zero, the lowest in Colorado. Administrators have not seen as dramatic a change in school performance, but they note an improvement in students' general attitude simply because students know there are adults available who have answers and will share them without judging. Teachers' attitudes have also improved as they see more children staying in school instead of getting pregnant and dropping out.

School sources report that the school-based health program has identified many previously undiagnosed problems that were interfering with students' ability to learn, including malnourishment and Attention Deficit Disorder. Students credit the program with improving their ability to make decisions about risky behaviors.

For more information about HRSA BPHC school health programs, please contact the school health staff at 301-594-4450.

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